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# The Journal

## OF THE KENTUCKY STATE MEDICAL ASSOCIATION

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NO. 1

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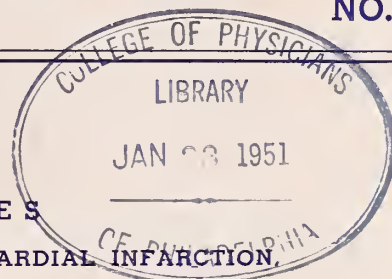
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**PARKE, DAVIS**



# *The* JOURNAL *of the* Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 49

JANUARY, 1951

NO. 1

## THE TREATMENT OF CORONARY OCCLUSION WITH MYOCARDIAL INFARCTION

J. T. Gilbert, Jr., M. D., and Frank H. Moore, M. D.

BOWLING GREEN

The treatment of coronary occlusion with myocardial infarction has long been a subject of much discussion and controversy, as is usually the case in diseases for which there is no standardized treatment. However, since the mortality and morbidity is so high, we feel it is important to frequently discuss therapy of myocardial infarction and exchange ideas concerning it.

### Drug Therapy

The prompt relief of pain is mandatory, and in our hands this has been best accomplished through the intravenous administration of morphine sulfate gr. 1/4 and atrophine gr. 1/75. If the pain is not relieved, the morphine may be repeated. It should be given about every four hours as long as the pain persists. Oxygen, either by means of a tent or intranasal catheter, is frequently a life-saving measure. The concentration of oxygen in the inspired air is usually considered to be higher when a nasal tube is used, however, for prolonged use especially in hot weather the tent gives the patient more comfort.

Aminophylline<sup>1</sup> 0.5 gram is usually given intravenously but may be given in the muscle or by suppository in the rectum. Aminophylline should be used with caution in the patient who has had a marked fall in blood pressure or in those in shock, because it is a vasodilator and may increase the hypotension. Nausea and vomiting also may occur.

Atropine sulfate<sup>1</sup> grain 1/150 is given subcutaneously every 4 hours, because it depresses the vagus nerve which is thought to transmit vaso-constrictor impulses to the coronary arteries. The vaso-constrictor impulses arise as a result of a reflex from the damaged myocardium.

Theocalcin<sup>1</sup> with Phenobarbital is given every six hours because of its vasodilating and mild sedating effect. Phenobarbital is frequently all that is necessary for discomfort after the initial dose of morphine.

### Hospitalization

Hospitalization is recommended for the best management of these individuals because oxygen, facilities to combat shock, and laboratory work necessary for anti-coagulant therapy are seldom available in the home. Absolute bed rest is necessary except for use of a commode chair which may be used after the first 48 hours. Straining at stools should be eliminated through use of mineral oil and the commode chair. Rectal impaction should be watched for and broken up if it occurs. Enemas are usually avoided for the first three days. At that time a mineral oil retention enema is frequently resorted to if the patient complains of abdominal discomfort.

### Treatment of Shock

Shock, when it is present, must be successfully combatted if the subject is to survive. Plasma, 10% glucose in distilled water and whole blood may be used. In extreme cases adrenalin 3-5 minims may be used but with great caution because of

Medical Staff, Graves-Gilbert Clinic, Bowling Green.  
Read before the Kentucky State Medical Association,  
Louisville, September 28, 1950.

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danger of precipitating ventricular fibrillation. Suppression of urine with rise in the NPN may follow shock, and adequate fluids are needed to correct this.

### **Congestive Failure**

Congestive failure is a very frequent complication and we do not hesitate to digitalize the patient when it occurs. Digitoxin .2 mgms t.i.d. for two days is given. The further administration is governed by the pulse, EKG and clinical condition of the patient. Mercurial diuretics are frequently very helpful in the presence of pulmonary congestion or dependent edema. We prefer Thiomerin in 1-2 cc. doses, because it can be given subcutaneously with little soreness and because of a less violent but more prolonged diuresis.

We believe quinidine to be indicated in the presence of sudden onset of auricular fibrillation, auricular flutter, ventricular extrasystoles, ventricular tachycardia and ventricular fibrillation. It is given in .2 gram dosage three to eight times daily. In fibrillation, .2 gram is given hourly until it is stopped or ten doses are given.

The patient is usually not hungry at first so that adequate fluids are the chief consideration. As the appetite increases, a soft diet with restricted sodium is given and later a regular bill of fare may be ordered.

Visitors and any form of excitement, stress or strain are to be strictly avoided.

### **Thrombo-embolic Phenomena**

Thrombo-embolic phenomena are among the most serious and common complications of coronary occlusion. These may manifest themselves by a second occlusion; mural thrombosis; emboli to lungs, spleen, kidney and brain; and thrombophlebitis. Anticoagulant therapy has recently become generally used. Wolff and White<sup>2</sup> in 1926 stated that mural thrombi almost always develop over the infarction. Meakens and Eakin<sup>3</sup> in 1932 again emphasized the importance of this phenomena, stating that it occurred in 46.7% of their 62 autopsied cases. Bean<sup>4</sup> in 1938, in his own series and collected cases from literature totalling nearly a thousand in all, found 46% to have intracardiac clotting. Solandt and Best<sup>5</sup> in 1938, using heparin in dogs with artificially produced coronary occlusion, found that thrombi were greatly reduced or prevented. Blumer<sup>6</sup> in 1937, Garvin<sup>7</sup> in 1941, Nay and Barnes<sup>8</sup> in 1945, Hellerstein and White<sup>9</sup> in 1947 and Bean<sup>10</sup> in 1949, all emphasized the im-

portance of emboli as cause of death after the first few days. Garvin<sup>7</sup> showed that emboli are much more common in the presence of mural thrombi.

### **Value of Dicumarol**

Dicumarol, because of its ease of administration and low cost, has gained widespread use and many investigators<sup>11, 12, 13</sup> have reported favorable effect upon the morbidity and mortality of coronary occlusion. We believe it has a definite rationale because as Bean<sup>10</sup> has stated:

1. The chief cause of myocardial infarction must be related to thrombosis.

2. Thrombo-embolic complications, cardiac and systemic, play a big part in morbidity and mortality.

3. Anticoagulants reduce or prevent spread of initiating thrombus and the development of intraventricular mural thrombi and systemic thrombi with their attending threat of embolism.

4. Treatment with anticoagulant compounds must be practicable and without disproportionate risk.

Nalefski and LeRoy<sup>15</sup> in 1949 concluded from animal experimentation that dicumarol has no deleterious effect upon the healing of an infarction.

For the past 2½ years we have been using dicumarol, without heparin, routinely in all cases. We obtain a prothrombin time and then give 30 mgm. immediately even though it is only a suspected case. This is followed by 200 mgm. the second day, and 100 mgm. the third day. From then on, the dosage is adjusted to keep the prothrombin time between 30 and 60 seconds (Quick's 1 stage method<sup>16</sup>).

### **Value of Prothrombin Time**

All reports state emphatically that daily prothrombin times should be run, although Wright et al have carried 17 patients for months on an ambulatory basis, checking the prothrombin time only every 7-14 days. We have checked the prothrombin times every other day in 50 cases (21 cases of coronary occlusion and 29 others) and have had no serious bleeding. Our results compare favorably with other reported series, (9.5 percent mortality). If the prothrombin time is under 30, 100 mgm. of dicumarol are given that day and the following day. If it is over 30 but under 45, dicumarol is omitted that day but given the next. If it is over 45, it is omitted for two days. However, each case must be individualized and we have



no definite set rule. The level of the prothrombin time at which different individuals bleed is most variable. We do not hesitate to run daily prothrombin times on those individuals whose response to dicumarol proves to be totally unreliable. We have had 7 cases of bleeding out of 50 cases dicumarized and practically all of these were mild and controlled by withholding the drug. Three cases required 1 or 2 doses of 72 mgm. of vitamin K and one required a transfusion of whole blood. The only bad feature of this regime is that there is more chance of getting an occasional low or high prothrombin time than with daily checks. However, Wright<sup>12</sup> has shown that embolic phenomena can be successfully prevented in chronic rheumatics by dicumarol therapy when the prothrombin times are checked every 7-14 days. We started the every-other-day check because of the expense to the patient and not because we thought it was better, and in our opinion it has proven very successful. We check the urine frequently on the days when prothrombin times are not being run, particularly when there is any question. Microscopic R. B. C. frequently appear in centrifuged urine before there is any evidence of gross bleeding.

In our hospital the cost of each prothrombin time is \$6.00 and for a lot of our patients this is prohibitive on a daily regime. We have a small hospital and frequently only 1 or 2 patients are on dicumarol at a time. The cost in larger hospitals can be reduced because many more tests can be run for not much more than the price of one. However, if we felt that life depended on it, we would not hesitate to add the extra cost. In our meager experience we feel that we can control patients satisfactorily on the above basis. We have a reliable technician and her training includes the short course in Dr. Wright's laboratory in New York City Hospital. Daily prothrombin times work a hardship on an already heavily burdened laboratory which has only a full-time and a part-time technician. In addition daily venipunctures are not required. Quick's<sup>16</sup> one stage method is used employing prothrombin of Difco made from rabbit brain. Normal dried plasma put up in individual bottles, obtained from the Cappel Co. of Wayne, Pa., is used when a normal check is difficult to obtain. Our normals have ranged from 12 to 17 seconds. This therapy is usually carried out for 3 to 6 weeks, the last 1 to 3 weeks

usually at home with less frequent checks. We are not advocating this method for general use but are only showing what may be done in a small hospital.

### Long Range Management

The long range management of the individual is important if he is to survive and to become rehabilitated. We recommend that tobacco in any form be avoided. An ounce of whiskey, two or three times daily, may have some beneficial effect, but alcoholic excesses are prohibited. The uncomplicated case is allowed to gradually get up after the third week, and we prefer that they do no work for three months; then begin with light part-time work and gradually increase up to tolerance, individualizing each case.

In our small series of 21 cases there were 12 men and 9 women; 2 showed embolic phenomena clinically, 2 died, and 19 survived.

In our clinic we believe that anticoagulant therapy is indicated in practically all cases of myocardial infarction and that the use of dicumarol has materially reduced the extremely high morbidity and mortality which accompanies it.

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## DISCUSSION

**Lewis Dickerson, Glasgow:** Doctor Gilbert and Doctor Moore have given an interesting presentation. Especially interesting to me was their anticoagulant therapy, since our facilities and methods at Glasgow are similar to those at Bowling Green.

In crowding so wide a subject into the allotted time, it is impossible that they could have more than briefly outlined some of the important aspects of treatment. Unintentionally this has tended to leave the impression that all cases of myocardial infarction may be treated identically.

Any treatment of myocardial infarction should be designed (1) to reduce the work of the heart (2) to alleviate discomfort (3) to overcome shock and cardiac failure (4) to cope with complications. In some cases the presenting symptom is pain, in some shock, in others left ventricular failure, or both right and left ventricular failure. In each case there is no substitute for experienced and careful evaluation of the clinical picture.

Bed rest is the one universal method of treatment. Recently we have prescribed shorter periods of bed rest than was the custom several years ago. After evaluating serial sedimentation rates and the clinical picture, we have allowed mild cases two weeks of absolute bed rest, followed by two weeks of gradual getting out of bed, around the room and to the adjacent toilet. This is followed by a period of graduated activity outside the room. In these cases we carefully explain to the patient the nature of his illness and the meaning of the

limitation placed on his activity. In other cases that manifest chronic left ventricular failure, angina pectoris, or chronic right ventricular failure, prolonged bed rest is necessary and some must remain in bed permanently.

When left ventricular failure is the major picture, with or without shock, we give digi-toxin 1.2 mg. intravenously in 2 divided doses one hour apart or in extreme cases in a single dose, provided no previous digitalis has been taken. Papaverine in doses of 1 grain intravenously, followed by oral doses of 1½ to 3 grains every four hours, is recommended to dilate the coronary arteries, thus improving the cardiac efficiency and limiting the size of the infarct by improving the collateral circulation. Papaverine also seems to aid in reducing the narcotic requirement.

I am glad that Dr. Gilbert discussed the care of the bowels, since patients who are maintained on morphine tend to develop impaction. For this reason we prefer demerol to morphine since it is not constipating. However, it must be given at more frequent intervals since the effect lasts only 2 to 3 hours. Demerol also produces less respiratory and cerebral depression.

In the acute stage and when sedation must be prolonged we give a prophylactic dose of penicillin, since broncho-pneumonia so frequently complicates pulmonary congestion.

I am delighted to hear Dr. Pedigo's discussion of diet. It is an interesting new field. If Lipo Tropic substances and diet is effective, what will be the effect on underlying arteriosclerosis and atheromatous degenerations? Will the replacement of lipids promote further fibrosis, scarring, constriction of vessels or calcium deposits?

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**Nutrition of Older Women—Milk, or its equivalent in milk products, is the one food which gives the greatest factor of safety in diets of 1,600 calories or less. This fact was revealed by a detailed laboratory analysis of the diets and metabolism of eighteen women between the ages of 48 and 77 years. Their daily food intake frequently fell below 1,600 calories. One pint of milk per day increased the intake of protein, calcium, phosphorus, and several vitamins to the point where the subjects on the low energy intake did not show a loss of these nutrients.**

—Am. J. Public Health. (Sept.) 1950.

**To advocate the indiscriminate use of streptomycin, especially in moderately advanced or advanced cases of pulmonary tuberculosis, not only is premature but also carries with it certain dangers and drawbacks. Among the principal dangers in the use of this drug is its toxicity, which may seriously affect hearing, sight and kidney function and cause skin eruptions. At present, it can only be said that we have seen little in the treatment of well established pulmonary tuberculosis by streptomycin that gives cause for any great optimism regarding its curative value. Comm. on Tuberc., N. H. Med. Soc., New England J. Med.**



## CHRONIC HOARSENESS

Gordon L. Green, M. D.

LOUISVILLE

Hoarseness is a symptom, not a disease. It is so common that there are none of us who have not seen a patient with it and I dare say hardly any of us who have not experienced it at least once. The common and frequent occurrence of hoarseness and its acceptance by the laity as a trivial complaint of no particular significance has been the cause of many tragic and preventable deaths. It is true that many cases of hoarseness are merely an inconvenience and self-limited in duration, but on the other hand it may be a symptom of a disease which is 100 percent fatal.

Another pitfall is failure to properly examine the larynx and accurately diagnose the cause of hoarseness. Any individual who can open his mouth, regardless of age, can have his larynx examined. Any individual with hoarseness of three weeks or more duration should have his larynx examined. In most cases this is a simple office procedure accomplished by using a laryngeal mirror. Excessive gagging can usually be overcome by patience on the part of the examiner and the use of local anesthesia. If the patient still fails to cooperate, the examination warrants admission to the hospital where direct laryngoscopy can be done, under general anesthesia if necessary.

### Four Important Facts

In order to have a clear voice, it is necessary for the vocal cords to approximate and be tense. Any interference with this function will cause hoarseness. Among the many symptoms that we have to interpret, hoarseness is one of the easiest. It always indicates pathology of the vocal cords. Jackson<sup>5</sup> lists four important facts about hoarseness.

(1) Almost all disease of the larynx associated with hoarseness is curable if the diagnosis is made and especially if made early.

(2) In many cases if the diagnosis is not made early hoarseness is a death knell.

(3) In many cases hoarseness is the signal of disease that has 100 percent mortality.

(4) Carcinoma of the larynx is the commonest disease associated with hoarseness in adults. It is 100 percent fatal if the diagnosis is not made early. If it is made early it can be cured in 82 per cent of the cases by operation.

Weaver,<sup>1</sup> commenting on carcinoma of the larynx, says "a fair number of cases still remain unrecognized and untreated until the best chance of cure has been lost due to metastasis or local extension of the growth."

Also commenting on carcinoma of the larynx, Furstenberg<sup>3</sup> stated "85 percent of the patients come for examination six months or more after the appearance of an altered voice."

### Etiology and Duration

Damitz and Dill<sup>2</sup> reported a series of 300 consecutive cases of hoarseness at the Henry Ford Hospital from the standpoint of etiology and duration of hoarseness. They found vocal cord paralysis to be the most common cause and chronic non-specific laryngitis a close second. The duration of hoarseness before adequate diagnosis and treatment were instituted was as follows:

- |  |           |
|--|-----------|
| (1) Chronic non-specific laryngitis      | 8½ weeks  |
| (2) Vocal paralysis (post-thyroidectomy) | 3½ years  |
| (3) Vocal paralysis (otherwise)          | 2½ months |
| (4) Benign neoplasm                      | 2 years   |
| (5) Malignant neoplasm                   | 9½ months |
| (6) Tuberculosis                         | 2½ months |

Every individual with chronic hoarseness, unless the cause is obvious, deserves a complete physical workup. If a demonstrable lesion is found in a vocal cord and the etiology is questionable, it is extremely important that the patient have a complete blood study including serology, chest X-ray, and biopsy of the lesion. The old triad of tuberculosis, syphilis, and carcinoma must be ruled out in these cases. It must not be forgotten that any of these three may coexist at the same time.

The causes of chronic hoarseness are so numerous that it is impossible to discuss them all in the time allotted. We can dis-

cuss briefly a few of the more important causes that are found in children and adults.

### **Causes of Chronic Hoarseness in Children**

Chronic Laryngitis is due primarily to vocal abuse or some chronic focus of infection. Infection of the nose, sinuses, or pharynx will cause it, and the most common site is infected adenoids. Infection of the lower respiratory tree such as bronchiectasis can be a cause also, due to the trauma of coughing and bathing the vocal cords in infected material. Elimination of the focus of infection is the treatment.

Vocal Abuse results in trauma to the vocal cords which may cause edema and hemorrhage. It also causes the formation of small translucent nodules on the margins of the middle third of the vocal cords which interfere with approximation of the cords. These are called screamers nodes. The name suggests the etiology. The treatment is voice rest.

Papilloma is a benign epithelial tumor with papillary structure that occurs fairly frequently in the larynx at all ages. It is a cause of chronic hoarseness in children and may fill the larynx to such an extent that tracheotomy is necessary. It is a self-limited disease and frequently clears up at or near puberty. Treatment consists in removing the masses under direct laryngoscopy as often as necessary to keep an adequate airway. They have a persistent tendency to recur.

Cicatricial Stenosis with fixation of the arytenoid cartilages may occur following tracheotomy when the cannula is placed too near the cricoid cartilage. Various methods of dilating the stricture must be employed to overcome this condition.

Congenital Laryngeal Stridor is seen in very small infants. It is generally thought to be due to poor elastic structure of the larynx. No treatment is necessary unless there is extreme dyspnea requiring tracheotomy. The voice changes associated with puberty must be recognized.

### **Causes of Chronic Hoarseness in Adults**

Chronic Laryngitis is found secondary to infections of the nose, sinuses, and pharynx. It may be associated with chronic constitutional diseases of metabolic disorders. Overindulgence in smoking and alcohol are important factors. Definite changes of the vocal cords may follow excessive smoking and clear up

promptly when it is discontinued. Allergy frequently plays a part.

Voice Strain is a frequent cause and is found particularly in professional voice users such as salesmen, ministers, teachers, and singers. Excessive and improper use of the voice is responsible. Professional singers may develop small nodules on the margins of the vocal cords known as singers nodes. Voice rest and proper voice training is necessary to clear up these conditions.

Senile Atrophy of the vocal cords and intrinsic musculature of the larynx causes the weak tremulous voice seen in the aged.

Syphilis of the larynx usually occurs as the tertiary type. It is characterized by gummatous nodules, ulcers, and perichondritis followed by fibrosis and stenosis. Diagnosis is made by the blood serological test.

Tuberculosis of the larynx must be ruled out in young adults with chronic hoarseness. Pulmonary disease is practically always present, and the progress of the laryngeal disease is dependent on the pulmonary disease. Laryngeal involvement usually means a serious prognosis.

Vocal Cord Paralysis may be central or peripheral in origin. If central, there is usually an associated paralysis of the pharynx, lips or tongue. Peripheral lesions are due to involvement of the recurrent laryngeal nerve. The cause in most instances is a very serious one. A unilateral vocal cord paralysis produces a poor voice but no dyspnea. In bilateral paralysis dyspnea may be extreme but the voice is usually good. Paralysis may occur following thyroidectomy or it may be due to malignancy of the esophagus, enlarged glands in the neck, aneurysm of the aorta or some tumor mass in the mediastinum. Exhaustive efforts should be carried out to determine the cause of vocal cord paralysis since its presence usually indicates a serious condition elsewhere.

Hysterical Aphonia is an interesting condition frequently seen in women. It is purely functional. The patient does not bring the cords together properly when phonating and the resulting voice ranges from a weak whisper to varying degrees of hoarseness. When visualized the cords appear normal but don't approximate on phonation, however they will approximate normally when the patient is asked



to cough. The recovery is spontaneous and usually sudden. There was a mother who recovered her voice during a spell of anger when she began yelling at her children.

Hyperkeratosis or leukoplakia of the vocal cords occurs. It is seen as thickening of the cords or in the case of leukoplakia by the presence of white patches on the cords. This condition must be watched very carefully for malignant changes. One should not hesitate to do a biopsy if there is any doubt. Leukoplakia, if pronounced, should be removed and this can be done by electrocoagulation.

Benign Tumors of the larynx are frequently found and are a common cause of hoarseness. Their removal results in a cure and prompt restoration of the voice in most cases. Diagnosis is made by inspection of the larynx and removal biopsy. These tumors may occur as cysts, fibromas, amyloid tumors, papillomas, or hemangiomas. The tumor may be extremely small, yet seriously impair the voice. Close inspection of the vocal cords is sometimes necessary to see them. Care must be exercised in removing them not to injure the vocal cords.

### Carcinoma of Larynx

Carcinoma of the Larynx is generally thought to be found only in elderly individuals, but I have seen a patient, age 35, who had to have a laryngectomy. It occurs frequently enough in this age group that it shouldn't be overlooked. The same thing can be said about its occurrence in women, although it is more commonly found in men. Carcinoma of the larynx may be intrinsic where it involves the vocal cords of subglottic region, or it may be extrinsic where it involves the supraglottic region. The intrinsic type offers a better prognosis since it is confined within the cartilage of the larynx, produces symptoms of hoarseness earlier, and doesn't metastasize so soon. The extrinsic type metastasizes earlier and may do so before it produces symptoms of hoarseness that are of any significance. Carcinoma of the larynx is practically always squamous cell and frequently low grade in character. Diagnosis is made by visual inspection and biopsy. The treatment of choice is surgery either through removal of small lesions by laryngofissure or the larger ones by total laryngectomy. X-ray has some palliative value in the far advanced inoperable cases. If seen early enough carcinoma of the larynx offers an

excellent chance for a cure. If seen too late it is 100 percent fatal. Hoarseness is usually the only symptom in the early cases.

### Conclusion

Chronic hoarseness is a symptom and its implications may be very serious. The importance of an early and accurate diagnosis of conditions causing chronic hoarseness has been emphasized. A few of the more important causes of hoarseness have been briefly discussed.

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### DISCUSSIONS

George I. Uhde, M. D., Louisville: I, too, would like to emphasize the urgency of early examination of the larynx of any individual with hoarseness of three weeks duration or longer. Actually, I believe a direct laryngoscopy should always be performed without delay if the origin of the hoarseness is still unexplained following a thorough history, complete physical examination, and indirect or mirror laryngoscopy; otherwise a malignancy located in the subglottic space at the anterior commissure may be missed, as has often happened.

The usual cancer patient with hoarseness of several weeks duration has a small growth located within the true cord at the junction of the anterior and middle thirds. It is a simple procedure to remove this growth at this time and the patient retains a good voice. A few months later this typical growth usually has spread beyond the confines of the true cord so that it is necessary to remove the entire larynx resulting in complete voice loss, an increased death rate, and a long, difficult period of rehabilitation which is seldom completely satisfactory. Yet, although it is generally agreed that the latter statements are true, a study of one group of patients with advanced cancer of the larynx showed that the average patient reported to his physician within four weeks of the onset of the hoarseness but that when, unfortunately, the patient was assured that the hoarseness was of no serious significance, the patient did not return until ten months later for reexamination.

We must remember that the hoarseness occurring in a tubercular patient may not be tubercular but may be cancerous, luetic, or due to one of the other numerous causes.

Hoarseness from infectious laryngitis is of more serious import in children than in adults. The child's larynx is smaller, among other reasons, so that the danger of suffocation is greater. Tracheostomy is frequently required but the incidence of the latter may be reduced by the recent use of detergents.

Hoarseness may be a symptom following physical trauma to the larynx. Hoarseness in either the child or adult may be the only symptom of a small foreign body lodged in the larynx. The foreign body may be too small to cause dyspnea, or to be observed by mirror examination, but causes dysphonia as a result of secondary glottic swelling. There are other traumatic causes of chronic hoarseness, such as being struck on the larynx, improper and excessive use of voice at sports events, vomiting of the alcoholic, hysterical crying, swelling and ulceration of the mucosa over the arytenoid cartilages following prolonged use of stomach tubes, ulceration of the true vocal cords with or without the formation of granulomatous tumors following intratracheal anesthesia, and intralaryngeal burns caused by chemicals intended solely for the tonsils or pharynx.

Chronic hoarseness following thyroid surgery and due to abductor paralysis of the vocal cords is more common than generally realized. Not long ago I did a tracheostomy on such a patient with bilateral cord paralysis; the cords finally recovered completely. I believe that the cord paralysis following thyroid surgery is often due to temporary pressure on the inferior laryngeal nerve, so that recovery can ensue.

There are many other causes of chronic

hoarseness, such as laryngeal swelling associated with various metabolic, allergic, skin, and blood disorders. However, the purpose of this paper is apparently not to discuss completely the etiology of chronic hoarseness but to present sufficient information to convince this group that a complete laryngeal examination is indicated in any individual with hoarseness of three weeks duration or longer; and the diagnosis will usually follow.

**Alvin C. Poweleit, M. D., Covington:** I feel that Dr. Green has adequately discussed the subject in the time allotted to him, and yet I believe that there is one point that should be elaborated upon, i. e. the duration of hoarseness before adequate diagnosis and treatment were instituted. Roughly an interval of 8½ weeks (Chronic non specific Laryngitis) to 3½ years (vocal paralysis Post-Thyroidectomy) lapses before anything is done for the patient. Why should there be such an interval? Is the patient at fault or is it the Doctor? I am not prepared to say exactly who is to blame, but in studying the number of my cases in the past two years I found that in many cases of hoarseness it is difficult to talk the patient into a laryngoscopy for further study. I also found that many of these patients had been to other Laryngologists, previously and had refused examination, and so it goes, these patients drift from one Doctor to another becoming worse and worse and finally go beyond the realm of salvation.

My present policy in taking care of these patients (instituted about two or three months ago) is to laryngoscope them as soon as possible, usually within 24 hours after being seen, while the problem of hoarseness is still fresh in their mind. By adopting this procedure, I feel that the Doctor can not be accused of negligence or being dilatory.

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**The Associated Press reports the National Safety Council as authority for the depressing toll of deaths from accidents in 1947: 100,000 killed; 10,500,000 injured; economic loss \$6,700,000. Of the injured, 1,100,000 were hurt in traffic accidents. Home accidents caused 33,500 deaths, which is said to be an increase of 3 per cent over 1946; other accidents included 17,000 civilian occupational, 19,000 public occupational, and 1,600 military deaths. Apparently one out of every 14 persons in the country suffered a disabling injury in 1947.**

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**The hospital is a key location in which to conduct a case finding report. Many of the related factors of tuberculosis control such as nutrition, economic distress and social maladjustment are receiving constant study and at-**

**tention, but the basic solution remains one of action in mass case finding, diagnosis and treatment. The Importance of the Hospital as a Tuberc. Case Finding Center - Hospital Council of Greater New York and New York Tuberc. & Health A. - 1950.**

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**The great physicians of all time have understood that medicine is not a study of disease, but a study of man: an individual who is a member of a family and who is part of a community.....The purpose of medicine is to make available to all the people, in the greatest possible degree, the achievements of science as they relate to the promotion of health and to the prevention and treatment of disease. W. G. Smillie, M. D., New England J. Med. January 12, 1950.**



## SOME ASPECTS CONCERNING THE APPROACH TO ALLERGIC MANIFESTATIONS

Maurice Kaufmann, M. D.

LEXINGTON

Allergy may be defined as a condition of unusual or exaggerated specific susceptibility to a substance which is harmless in similar amounts for the majority of members of the same species. The term embraces all types of human hypersensitiveness.

It has been estimated that about ten per cent of the population of the United States have a major allergy. This is significant because first, allergy includes such well known manifestations as allergic asthma, allergic rhinitis, (both seasonal and perennial), atopic eczema, allergic migraine, gastro-intestinal allergy, urticaria and angioneurotic edema, and secondly, the majority of people with these conditions have symptoms of such severity that they seek and need medical attention and relief.

Furthermore, of the remaining ninety per cent of the population, many are potentially allergic and may become sensitized under certain conditions. The most noteworthy example of this induced hypersensitiveness is that resulting from the injection of foreign sera or antibiotics. Individuals who have acquired this type of hypersensitiveness will, upon injection of the specific agent, develop the usual clinical picture of urticaria, angioneurotic edema and arthralgia. The reaction may be so severe as to result in shock or even death.

### Hereditary Influence

Certain types of allergic conditions are subject to hereditary influence. For these conditions Coca has coined the term "atopy" which means strange disease. However, only the tendency is inherited, not the clinical manifestation nor the agent to which the patient is hypersensitive.

### Manifestations

Vaughn (1) states that "the manifestations of allergy are more varied than those of any other disease, due chiefly to the wide distribution of the shock tissues. The earlier diseases were put into this

category because of their resemblance to anaphylaxis. Later, maladies such as migraine and gastro-intestinal allergy were included chiefly because of association with, or points of resemblance to, the earlier more outspoken allergic diseases. The resemblance appeared in such factors as periodicity; attacks following exposure to specific substances with relief on avoidance; and the absence of demonstrable organic etiologic or pathologic changes. Still more recently diseases have been added to the group because of one or more points in common in the pathologic picture. The local eosinophilia of periarteritis nodosa serves as an example. Finally, some diseases have been placed in this category, not because of any resemblance but because allergy offers the best explanation available at the present time. An example of this is found in agranulocytosis." This list can be extended to include Meniere's disease, rheumatic fever, rheumatoid arthritis, sympathetic ophthalmia, intermittent hydrarthrosis, lupus erythematosus disseminatus, Loeffler's syndrome, and a host of others. The existence of allergy to drugs, metabolites, hormones, bacteria or bacterial products, or of allergy that is in some manner associated with infections is suspected of contributing to many of these conditions.

The shock tissue or organ may vary from time to time in the same patient as well as the response to a given allergen. On the other hand, a given patient may react in the same way to a variety of allergens acting simultaneously. For the most part, the shock tissues in man are in the skin and mucous membranes, although, as mentioned above, more recently other tissues and organs have become recognized as being involved in what is considered to be hyper or altered reactivity. It is well to remember that allergic manifestations are rarely static and a shift of reactions from one shock organ to another is of common occurrence. Many of us have observed an atopic eczema eventually disappear only to be followed by allergic rhinitis or bronchial asthma, or,

as is often the case, the eczema persists and other allergic manifestations become superimposed upon it. The excitant may remain the same or change; new sensitivities may develop or old ones continue; and finally, any combination or permutation of allergens and reactions may co-exist.

### Characteristic Symptoms

Prickman (2) asks "what criteria may be used to establish the allergic nature of any given syndrome?" Then states "by analogy with the microbic diseases (Koch's postulates), we may state such criteria as three postulates. First, the characteristic symptoms must result from natural contact with a substance which provokes no symptoms in the majority of individuals. Secondly, the symptoms must disappear when contact with the suspected substance is avoided or prevented. Third, the original reaction or symptoms must be capable of artificial induction at will on resumption of contact with the substance (inhalant, ingestant or injectant). True allergic reactions are consistent. One is not sensitive to milk one day and not again the next day *under equivalent circumstances*."

In contrasting immunity versus hypersensitiveness (or allergy) Boyd (3) says that the changes which occur in an organism in response to an infection may enable it to throw off the infection and are beneficial in the sense that resistance to subsequent infections of the same type will be greater. The mechanism of these changes, however, is evidently so general that they can be provoked by influences other than infectious agents. Noninfectious, dead micro-organisms may cause such changes and even apparently harmless substances may sometimes cause alterations in the reactions of the tissues or the substances in the circulation. An animal may become highly reactive (hypersensitive) to certain harmless substances.

"'Pseudo-defense' measures in the case of usually harmless substances such as ragweed pollen, may set up a mode of reaction which is deleterious to the organism and constitutes what we call allergy. We can only suppose that on the whole the benefits of possessing the immunity sensitization mechanism outweigh the harm, or otherwise the device would not have survived during the long course of evolution."

### Definition of Allergy

The word "allergy" was coined by von Pirquet from the Greek words *allos* ergon meaning "changed or altered reactivity" to denote any specific alteration in the capacity to react which occurs in living organisms or tissues upon exposure to living agents or inanimate substances. As originally framed, this definition was meant to include alterations in the direction of protection as well as in the direction of hypersensitiveness, so that, strictly, immunity would also be connoted by the word. However, the word allergy through common usage has actually lost the connotation of immunity and now implies only certain types of hypersensitive-ness.

Although the concept of allergy since it was first promulgated by von Pirquet still holds true, other clinical phenomena similar to those of allergy cannot be explained on a purely antigen-antibody basis. Of the various types of allergy, (atopy, familial non-reaginic allergy, serum sickness, drug idiosyncrasy, contact dermatitis, tuberculin type hypersensitiveness, and others), atopy is the only one in which an antigen (allergen) antibody-like (reagin) mechanism has been demonstrated through passive skin sensitization of non-allergic persons. The mechanism of the other types of allergy has not been as yet determined, although recently Rich (4), as well as Chase (5), has claimed the successful passive transfer of the tuberculin type of hypersensitiveness with tissues from sensitized animals. It may be that such a mechanism will eventually be shown to be the basis of all hypersensitive reactions.

### Phases of Development

Williams (6), correlating the work of a number of investigators, including Cannon (homeostasis), Kahn (tissue immunity), Muller and Parrisius (the spastic atonic state), Brown, and Peterson and Milliken (resistance to environmental change), and Selye (the general resistance mechanism) has proposed what he terms "a phylogenetic concept of allergy." This concept, he feels, "interdigitates with the observed facts, avoids the confusion that now exists as to the various mechanisms involved in allergy and greatly broadens the field of therapeutic possibilities." According to Williams, there are four phases to this concept. The first is that allergy is a clinical phenomenon and that the



diagnosis of allergy is primarily made by observing the changes occurring in the functions of tissues and organs and by the lesions which may be present.

The second phase is that the physiologic mechanism that has to do with the organism's adjustment to changes in the external and internal environment is the autonomic nervous system. He refers to this as physical allergy. Cannon (7) has applied the term "homeostasis" for this tendency of the organism. From the phylogenetic point of view Williams believes that it is reasonable to assume that when the organism was unicellular or consisted of relatively few cells, physiochemical disturbances could readily reestablish equilibrium. However, as phylogeny progressed it required the elaboration of some system that would enable the organism to function more efficiently in order to regain homeostasis. The hormonal system developed to speed up these necessary biochemical changes. In addition, reactions concerned with changes in cellular metabolism involve the capillary bed, and these reactions have been shown to have a tendency to be inherited in susceptible individuals. Anoxic conditions may result at these tissue areas and anoxia produces increased capillary permeability as well as leukocytolysis. In support of this contention Williams cites findings that in the human being most of the histamine in the body is contained in the white blood cells and that if they are destroyed as in the above reaction, histamine is set free to increase further capillary permeability which gives rise to the typical allergic wheal, a localized collection of extracellular fluid. This is an apparent "allergic" manifestation in which an antigen antibody mechanism appears to play no part. The histologic picture is the same as that seen in "humoral" allergy. Here we see the group of "physical allergies" to which, according to Duke (9) the majority of so-called allergic conditions belong.

The third phase Williams refers to as bacterial or tissue allergy. He states that as phylogeny proceeded, the organism was required to modify itself for protection against invading micro-organisms and yet retain the fundamental mechanism for homeostasis. Therefore, certain globulins were elaborated to combine with, and to enable the body to eliminate protein sub-

stances resulting from the digestion of specific bacteria. The specific immune globulins elaborated by certain cells (antibody) may interact with the other tissue cells (antigen) at the cell membrane or within the cell, resulting in cell injury with the release of toxic substances. These toxic materials might include histamine, the "H" substance of Lewis and others, and these could produce the same fundamental damage or vascular change as seen in physical allergy. Furthermore, many investigators have stressed that allergy is primarily a vascular phenomenon. They have pointed out the Arthus phenomenon for example, could not be produced in an area devoid of blood vessels. It must therefore, be considered a normal resistance mechanism. It is fundamentally a granulomatous inflammation. In allergic lesions produced both clinically and in the laboratory, necrosis of the collagen fibrils is the earliest observable pathologic change. The granulomatous inflammation which occurs nonspecifically, as in idiopathic granulomas, lupus erythematosus disseminatus, or periarteritis nodosa as the result of the hyperactivity of a physiologic mechanism, (as Rich (9) has shown) may then be considered allergy.

The fourth phase embraces humoral or circulating antibody allergy. Here the antigen-antibody mechanism is present in the tissue cells and antibodies are present. Suppurative inflammation is associated with an abundant production of circulating antibodies and is the normal precursor of "humoral" allergy. It has been shown that certain abnormal individuals will develop, toward harmless nontoxic proteins, an immunologic reaction similar to that developed by a normal individual against virulent bacterial toxin. In these individuals "sensitizing" antibody will be present in the blood serum. A reaction, similar to that discussed above, also takes place in the cell or at the cell membrane resulting in cell injury with the release of the aforementioned toxic substances.

Williams concludes that "the proposed phylogenetic concept presents 'allergy' not as an unprecedented kind of injurious mechanism which the animal organism has developed and preserved, a hypothesis which seems to be in conflict both with the evidence and with common sense and singularly unfruitful in the production of

favorable clinical results for patients, but rather as the gradual growth in the animal organism of an increasingly more elaborate defense mechanism rather than replacing it. The concept of allergy as a hyperfunction or dysfunction of this stereotyped mechanism does not appear to be in conflict with any of the observed facts. It explains the gradual, rather than the abrupt, transition from one type to another, and why there may be a mingling of the types. It also explains why, since the circulating antibody would appear to be a rather late phylogenetic development, it is not possible to discover circulating antibodies in so many subjects with clinical allergies."

With the preceding etiologic and pathologic concepts as a background it is apparent that the purely immunologic approach to allergic problems has many shortcomings. Yet the experience of over a generation of investigative thought directed toward the antigen-antibody concept of allergic reaction cannot be entirely ignored. Not only is it a basis to which allergists have become accustomed and on which they are dependent but it is still of major importance in accounting for many inhalant allergies, particularly, those due to pollen. It is time however, that we begin to free ourselves from the dogmatism that the whole answer to these enigmatic diseases lies in a series of skin tests. Total reliance upon the immunologic approach fails to detect all the other types of allergy for which an antigen-antibody mechanism has not been demonstrated. But we are not yet ready or able to forsake all of the knowledge that has been gleaned from the immunologic theories and practices. Here, as in many other fields, it is the proper use and interpretation of a laboratory test that determine its inherent value.

#### **Importance of History-Taking**

The art of taking a good allergy history, which includes the amount of time consumed in taking it and the ability to properly evaluate it, still remains the sheet anchor of the allergic diagnosis. This is not the place, nor is it the purpose of this paper to go into details. However, some of the important points of such a history may be briefly mentioned. The chief complaint; duration of the illness; when, where and how the symptoms began; the season of the year or the time of day when the symptoms are worse; the course of the disease; any precipitat-

ing or aggravating factors; what, if anything, relieves the symptoms; detailed account of the symptoms of the particular tissues or organs involved; systemic review; other allergic manifestations; family allergy history; and possible home and occupational contacts with allergens; and the patient's own opinion as to the causative agents of his illness. These questions and others properly applied should give some very definite leads. After all, the allergist in many ways is simply a medical detective seeking clues, assimilating them, sifting them, then finally solving the allergy mystery. On the surface, at least, it would appear easy to relieve allergies, find the cause then remove or avoid it.

The allergist must enlist the aid of every device that might help him in ferreting out specific etiologies. Skin testing is just one such tool. As mentioned above, there is much to be desired in this diagnostic measure but in those hypersensitive phenomena where an antigen-antibody reaction is known to be involved it remains a most worth while procedure. Possibly its greatest value is in pollen allergy, next in other inhalant allergies and least in food allergy.

#### **Diagnosis**

In respect to the diagnosis of food allergy, again, the employment of a very careful detailed history and the use of proper elimination diets yield the best results. Inquiry should be made concerning food idiosyncrasies, specific food dislikes, reactions to foods (both qualitatively and quantitatively), effect of certain cooking odors, and the past history of colic or other gastrointestinal disturbances due to foods. A good dietary history is of necessity a time consuming procedure, requiring on the part of the physician a consummate knowledge of dietetics biology of foodstuffs, and nutrition, and a mastery of culinary art. The role of elimination diets, whose greatest proponent is Rowe (10), assumes enormous significance when adequately and conscientiously applied. On the part of the patient (or the mother if the patient is a child) it requires sacrifice, patience, and intelligent cooperation. It should be remembered that it may take weeks, not days, before the omission of an offending food or foods will alleviate symptoms. There are various and sundry types of elimination diets and a rotation of these may be required before the food culprit is discovered.



### Medical Approach

The value of a thorough competent medical approach to allergic disorders cannot be overemphasized. Care and attention must be given to the patient's general condition including such factors as age, sex, fatigue, physical exhaustion, nervous and emotional states, metabolic or hormone imbalance, and infections, both obvious and cryptic. Other important considerations include the patient's social and economic status and the effect of climate on his condition.

Finally, there is a long list of manifestations mentioned earlier, which are now considered as allergic in origin that require an entirely new approach as to diagnosis and treatment. I am referring to the collagen diseases. The advent of adrenocorticotrophic hormone (ACTH) and Cortisone may revolutionize the management of many of these complex syndromes.

### Conclusion

In conclusion, the allergic reaction is a defensive process, a warning on the part of nature that the cells of the body have encountered a noxious substance. Against this threat there is a mobilization of forces involving the cells, tissues, autonomic nervous and hormone systems to protect the organism against the invader. The best management of allergic diseases is to find the cause, then remove it or avoid it. Prophylaxis would be still better if we could determine the allergic diathesis before the development of overt symptoms. Antigenic substances or materials in the

environment that can be removed or avoided requires doing just this, whether it be an inhalant, ingestant, injectant or contactant. If this is impossible, for one reason or another, other methods must be employed. Probably the most beneficial of these is hyposensitization to specific allergens. Extracts of pollen, dust, mold, and bacteria being most often used for this purpose, depending on which is the offending agent. In food sensitiveness, there is no excuse for not removing offenders from the diet as there are other adequate and satisfactory nutritional substitutes. This is also true in drug sensitiveness. Symptomatic relief is readily afforded by the host of sympathomimetic and antihistamine medications at our disposal. Lastly, the patient as an individual, not the disease, must receive every care and consideration.

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**Of the deaths from respiratory tuberculosis** in 1947, 32.1 percent occurred outside of institutions, and 67.9 percent occurred in institutions. Of the total respiratory tuberculosis deaths, 25.8 percent occurred in general hospitals, 30.9 percent in tuberculosis hospitals and sanatoria, and 9.0 percent in mental hospitals. Sara A. Lewis (biostatistician) Pub. Health Rep., April 1, 1949.

**Carefully documented studies on the use of streptomycin** in clinical tuberculosis have established the fact that this new anti-bacterial agent exerts a beneficial therapeutic effect on several forms of tuberculosis. At its best, however, it is only an auxiliary part of the general treatment in most forms of the disease, and is partially dependent, for its full effect, upon

other more common therapeutic measures, such as bed rest, pneumothorax, and chest surgery. (Recommendations of the Subcommittee on Streptomycin of the Expert Committee on Tuberculosis of the World Health Organization, January, 1949).

**We have learned that you cannot put a patient's mind in a cast.** The tuberculosis experience is an interesting example of this. The great problem of the tuberculosis sanatorium is people living against medical advice. We have been foolish enough to expect patients to rest idly in bed and not to worry, but worries about families, jobs or money, go round and round in their heads until they decide to give up treatment and go home. Howard A. Rusk, M. D.

## TRENDS IN OBSTETRICAL PRACTICE

### A Study of Twenty-five Years of Obstetrics in Saint Joseph Infirmary

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Obstetrics and Gynecology have become a distinct specialty in Medicine, utilizing all the advances of medical science to minimize the discomforts and prevent the hazards of pregnancy, labor and the puerperium, and reduce maternal and fetal mortality.

In order to appraise the results of 25 years of Obstetrical practice in Saint Joseph Infirmary, a study of 21,005 consecutive births was undertaken. The following paper is based on this study. It will be discussed in three parts:

- I. Trend affecting Obstetrical care.
- II. Trends affecting the conduct of labor.
- III. Maternal and Fetal Mortality.

#### Part I. Obstetrical Care

Basically, the quality of obstetrical care is dependent on the training and calibre of the general practitioners who deliver the majority of women admitted to obstetrical department of a hospital. (It is of interest that 92% of the births in Kentucky are attended by physicians).

The recent reorganization of the department of Obstetrics and Gynecology and the establishment of an approved resident training program at Saint Joseph Infirmary has consolidated the specialist and the general practitioner into an efficiently functioning Obstetrical unit. Both can work without any infringement on the right of the other to practice good obstetrics. The general practitioners have an added advantage in having consultation and assistance at any time without embarrassment or fear of loss of his patient. That they have taken advantage of this service is exemplified by a 15% increase in obstetrical consultations during the past 10 years.

Obstetrical care must include complete prenatal and post-partum observation and treatment. It is impossible to give this type of service without the full cooperation of the patient and adequate medical

facilities. It is the efficiency of this care which will prevent the majority of obstetrical calamities. The general enlightenment of the public and the refusal of most physicians to do a home delivery when hospital facilities are available are mainly responsible for the increased number of hospital births.

TABLE 1  
INCREASE IN OBSTETRICAL  
HOSPITAL ADMISSIONS

New England Area	97-98%	
East South Central Area	55%	
Rural Communities	67.1%	
Urban Communities	92.5%	
United States	1944-75.6%	1946-82.4%
Kentucky	1944-38.3%	1948-58.0%

During the past 25 years this trend has been evident throughout the United States. (Table I) In the New England area, 97-98% of the births occurred in the hospital; in the east-south central area, only 55% were born in hospitals. In rural communities<sup>1</sup>, the incidence was 67.1%; and in urban communities, 92.5%. Hospitalization in Kentucky<sup>2</sup> has increased from 38.3% in 1944 to 58% in 1948. At St. Joseph Infirmary 10,428 women were delivered during the past 5 years, which is equivalent to 49.6% of its total obstetrical admissions during the past 25 years.

TABLE 2  
SAINT JOSEPH INFIRMARY  
DELIVERIES 1925-1949

1925-1949 (25 yr.)	21,005	100%
1925-1944 (20 yr.)	10,577	50.4%
1945-1949 ( 5 yr.)	10,428	49.6%

#### Hospitalization

The hospitalization of the parturient woman bears a definite relationship to maternal and fetal mortality. This rate being highest where hospitalization rate is the lowest.

#### Part II. Conduct of Labor

In recent years the conduct of labor has gradually changed due to:

- (a) The use of chemotherapy, antibio-

From the Department of Obstetrics and Gynecology, St. Joseph Infirmary, Louisville.



tics, blood and blood substitutes.

- (b) The increased use of pain relieving drugs (Analgesia and anesthesia).
- (c) The use of prophylactic forceps.
- (d) The utilization of the episiotomy.
- (e) The broadened indications for Cesarean Sections.

### **Chemotherapy, Antibiotics, Blood and Blood Substitutes**

Chemotherapy and antibiotics minimize the danger of puerperal infections and allow for more conservatism in the conduct of borderline cases. Blood and blood substitutes help in the prevention and treatment of hemorrhage and shock. During the past five years no maternal death has occurred as a result of infection, only one woman died of puerperal sepsis in the past 10 years.

### **Analgesia and Anesthesia**

As in other institutions, this hospital has gone through the evolutionary cycle of drugs and gases for the minimizing of labor pains. Although great advances have been made in our knowledge of the pharmacological and physiological effects of these agents on the mother and intrauterine infant, no perfect system has been devised.

Since November 1948, 3597 cases or 65% of our obstetrical admissions during that period, exclusive of Cesarean sections, were delivered under saddle anesthesia using (with minor modifications) the method advocated by Adriani and Roman Vega<sup>3</sup>. Demerol (100 mgms) and Scopolamine (0.4 mgms or 1/150 gr.), with or without barbiturates are used prior to the introduction of the spinal drug. Heavy nupercaine, metycaine and pontocaine, with or without neosynephrine, are used with satisfactory results. The difference between these drugs is the duration of anesthesia.

In our series, 26% received supplemental gas (nitrous oxide, cyclopropane and O<sub>2</sub>, or ether). This high percentage of supplemental anesthesia is due to a number of factors:

1. The desire of physician to have patient asleep.
2. The desire of patient to be asleep.
3. The return of abdominal pain, and traction pains due to forceps.
4. The reluctance of physicians to repeat saddle when labor is longer than expected.

Our incidence of complete failure has been only 1%.

It is not a wise policy to advocate a routine type of anesthesia. Because it has been necessary for the obstetrician to assume complete responsibility for the relief of pain during the first and second stages of labor, we have adopted Saddle Block anesthesia rather than to subject mother and intrauterine infant to heavy sedation, and deep gas anesthesia by untrained personnel.

At this hospital the administration of saddle anesthesia is done by the resident staff. Supplemental gas is administered by a trained nurse. However, the need for deep prolonged anesthesia is minimized by the preliminary spinal drug.

Except for the occasional slowing of the progress of labor and the increased incidence of posterior positions, we have found the saddle anesthesia a very safe and satisfactory anesthesia for mother and infant. The only complication has been the post-spinal headache which has been severe in 2-3% of our cases and mild in 7%.

The proper use of a Pitkin type of spinal needle No. 24 gauge in a No. 20 sleeve needle, or a No. 26 gauge in a No. 21 sleeve needle will prevent most headaches. A careful technique and a properly hydrated patient is essential for success of the procedure.

### **Prophylactic Forceps**

The present attitude toward analgesia and anesthesia has practically eliminated the patient's cooperation during the termination of the second stage of labor. Except in the multipara, when delivery can sometimes be accomplished by the use of fundal pressure, forceps must be used to complete the delivery.

During labor some degree of structural damage to the perineum, vagina and cervix will occur. Only the degree of damage can be controlled by the proper conduct of labor. DeLee<sup>4</sup> called labor pathological. Titus<sup>5</sup> stated that it was "a mistake to consider labor a physical process to which the physician condescends to lend assistance, but rather should look upon it as a procedure which may present emergencies to tax his best surgical and obstetrical skills and judgment "without warning."

The use of the prophylactic low forceps<sup>6</sup> in order to shorten the second stage of labor (after complete cervical dilatation

with the head on the perineum), has gained universal acceptance. The incidence of spontaneous deliveries (Fig. 1, 2), especially in the private hospital has gradually decreased in number. In 1942, approximately 75% of all deliveries at St. Joseph Infirmary were recorded as spon-

taneous, and in only 17% were forceps used. In 1949, the use of forceps has increased to 82%, and spontaneous deliveries reduced to 14%.

### Episiotomy

The use of the episiotomy has also become an established procedure. In 1928, 4% of all cases (only primipara) received a preliminary episiotomy; 42% were lacerated. In 1948, 5% had episiotomies, 8% lacerations. This excludes extension of the episiotomy which is seldom reported.

The effectiveness of a low forceps application and the episiotomy in reducing the fetal and maternal morbidity and mortality is dependent on the skill of the operator. Improperly applied forceps and a poorly made episiotomy are a hazard to mother and child. Delaying the episiotomy until the perineum is blanched and the submucosal fascial structures are stretched and torn, severely damages the pelvic floor and results in disabilities which necessitate future surgical repair.

It has been our impression that with the use of saddle anesthesia, prophylactic forceps and episiotomy, the incidence of cervical laceration and post-partum eversion of the cervix are greatly reduced. It is worth noting that there has been a marked decrease in the number of babies needing resuscitation, since the adoption of these procedures.

### Cesarean Section

The attitude toward operative obstetrics has been revised in recent years. Adequate, available blood, chemotherapy, antibiotics, and surgically trained obstetrician-gynecologists have made Cesarean sections a relatively safe procedure. Obstetrical complications requiring the use of high forceps and podalic versions are accompanied by a higher fetal and maternal mortality.

Our Cesarean section rate has increased from 2.1% to 2.85% in the past ten years. Compared with other hospitals our rate is comparatively low (Table 3).

Douglas<sup>7</sup> has recently reviewed the recent trends in the operative technique in Cesarean sections. Prior to 1940, 90% of our Cesarean sections were of the classical type, since then 94% have been of the low flap type as advocated by DeLee and Beck. No extra peritoneal sections have been done at this hospital, for we have followed the teachings of Dieckmann<sup>8</sup> of Chicago who advocates the use of Ces-

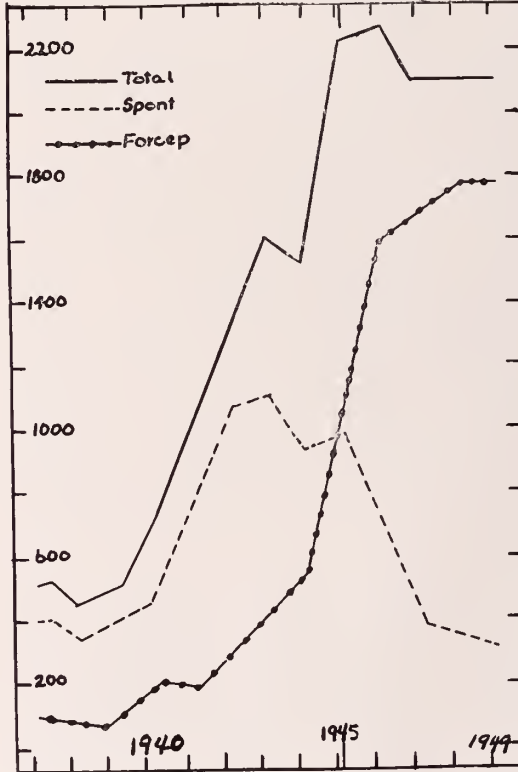


Fig. 1: Solid line indicates total number of deliveries. Interrupted line indicates the number of spontaneous deliveries. Dotted line indicates the number of forcep deliveries.



Fig. 2: Solid column indicates percentage of normal spontaneous deliveries. Thick diagonal lines indicate the percentage of forcep deliveries. Horizontal lines indicate traumatic or operative vaginal deliveries. Vertical lines indicate the percentage of Cesarean sections.

TABLE 3  
CESAREAN SECTION RATES

Sloane Hospital	7.82% (private)
	4.47% (ward)
Kansas City	7.1%
Cleveland Maternity	6.1%
New Haven Hospital	5.9%
Johns Hopkins Hospital	5.5%
Chicago Lying-in	5.5%
Margaret Hague	2.6%
New York-Cornell	2.1%
Saint Joseph Infirmary	2.4% (average)
	2.85% 1940-1949

arean hysterectomy for the grossly contaminated cases.

A recent article by D'Esopo<sup>9</sup> adequately describes the broader indications for the use of Cesarean sections. He believes that "an upward trend of the Cesarean section rate in any service is justified only if it can be shown first that the increased number does not increase the maternal mortality and second, if it is consistent with a fall in traumatic vaginal operations and obstetrically preventable fetal deaths."

### Part III. Maternal and Fetal Mortality

**Maternal Mortality:** Although modern obstetrical principles and procedures, carried out in a well equipped hospital has greatly reduced the fetal and maternal morbidity, the efficiency and reputation of an obstetrical department is primarily judged by its maternal mortality and the stillborn and neonatal death rates.

During the past 25 years our maternal mortality has been reduced from a high of 7.1 per 1000 live births to a new low of 0.8% in 1949. There has been 68 deaths recorded of which only 25 or 35% occurred during the past 10 years. (During this same period 15,777 or approximately 75% of all our deliveries occurred.)

The national maternal mortality rate has similarly dropped from 7% per 1000 live births to 1.1% in 1948. For the entire commonwealth of Kentucky, the rate in 1948 was 1.5% per 1000 live births.

An analysis of the 25 maternal deaths which occurred from 1940-1949 (Table 4), reveals that a ruptured uterus accounted for six deaths, five of which were the result of traumatic deliveries and one was

TABLE 4  
ANALYSIS OF MATERNAL DEATHS  
1940-1949

Diagnosis	Cases	Associated Factors	Cases	Classed As
RETAINED PLACENTA	3	undiagnosed	1	Post-part. H.
		home delivery	2	Post-part. H.
TOXEMIA				
Eclampsia	6	necrosis of viscera	1	Cardiac F.
		convulsions prior to admission	5	Eclampsia
		undelivered	1	Eclampsia
		Caesarean section	2	Eclampsia
Acute Yel. Atrophy	1			
RUPTURED UTERUS	6	traumatic del.	5	Post-part. H. and Shock
		spont. (previous Caesarean sect.)	1	Post-part. H. and Shock
		undiagnosed	3	Post-part. H. and Shock
EMBOLISM				
Pulmonary	1	Caesarean sect.		
Cerebral	2	pre-partum	2	
PLACENTA PRAEVIA	3	rheumatic heart Caesarean sect.	1	Cardiac F.
		post-partum pneumonia	1	
		kag induction	1	Post-partum H.
INFECTION	1	eversion uterus post-partum h.	1	Septicemia
PYELONEPHROSIS	1	undelivered		
PLACENTA ABRUPTIO	1	severe toxemia Caesarean sect.		Cardiac F.





Fig. 3: Solid line (P) indicates the number of premature infants born per 1000 live births. Interrupted line (N) indicates the number of full term and premature infants which died (neonatal) per 1000 live births. Dotted line (F) indicates the number of stillbirths or fetal deaths per 1000 births.

the result of the spontaneous rupture of a previous Cesarean scar. Three of these cases were unrecognized until post-mortem examination, one uterus having been ruptured prior to admission.

There were six deaths due to eclampsia, of which five had had more than one convulsion prior to admission. In one case an associated post-mortem finding of com-

plete liquifaction necrosis of the diaphragm, stomach and lungs was found. This patient had had poliomyelitis during the pregnancy. One patient died undelivered.

Three women died as the result of a retained placenta. Two of these patients were delivered in the home and sent into the hospital in moribund condition. One case went undiagnosed ante mortem, death being due to uncontrolled hemorrhage.

Of the three patients with placenta previa who died, one had an associated rheumatic heart and was subjected to a Cesarean section; her death was attributed to heart failure; a second died as a result of pneumonia following Cesarean section (1940); a third died of uncontrollable post-partum hemorrhage following a bag induction.

Pulmonary embolism was the cause of death on the ninth post-operative day of a patient sectioned for cephalopelvic disproportion. Two patients suffered antepartum cerebral emboli, one died undelivered. Placenta abruptia complicated a severe toxemia requiring patient to have a Cesarean section. Her death was attributed to cardiac failure.

One woman died of pyelonephrosis prior to delivery.

#### Average Age

Thirty years was the average age in the cases reviewed. There were only three primigravida. Three cases died on admission; three died on the delivery room table. Twenty-one cases died within the first twenty-four hours after admission to the hospital.

Maternal deaths associated with Cesarean sections, 1940-1949, are outlined in Table 5. During this period, there were

TABLE 5  
MATERNAL DEATHS ASSOCIATED  
WITH CAESAREAN SECTION, 1940-1949

Year	Indication	Type	Cause of Death	Time Death Post-Partum
1940	Placenta Praevia	Classical	Pneumonia	5th day
1943	Toxemia (Eclampsia)	Classical	Eclampsia	11 hours
1945	Disproportion	Classical	Embolism	9th day
1946	Toxemia, Rheumatic Heart	Classical	Cardiac F.	15 hours
1946	Toxemia	Transverse Low Flap	Cardiac F.	3 hours

#### SUMMARY

Years	Deliveries	Caesareans	Deaths
1940-1944	5,349	111	3
1945-1949	10,428	297	2



408 Cesarean sections performed with a total of five deaths. During the past five years there were 10,428 deliveries, including 297 Cesarean sections, with only 2 deaths, a rate of approximately 0.7%. This compares favorably with other hospitals.

It should be stated emphatically that the majority of maternal deaths associated with Cesarean sections are not primarily related to the surgical procedure but to the underlying disease or indication. Cesarean section is an unsatisfactory substitute for good obstetrical judgment and technique.

### Fetal Mortality

In 1948, Mengert reported that approximately 4% of all fetuses and newborns reaching the size and development compatible with extrauterine existence die before or soon after birth. In most of these deaths, the precipitating cause occurs during labor.

During the past 25 years this hospital has enjoyed a decreasing infant mortality and stillbirth rate. From a high of 35 stillbirths per 1000 births in 1930, the rate has dropped to the present low of 13 per 1000 births. During this same period, the neonatal death rate ranged between 24 and 30 per 1000 live births, until 1945 when it started to drop to the low of 21 per 1000 in 1949. The drop in the neonatal death rate takes on more significance when we note that during the past ten years the number of premature births has increased from 39 per 1000 births, to 65 per 1000 births. Prematurity is listed as our most common cause of neonatal deaths.

An analysis of the causes of fetal and neonatal deaths will not be taken up in this paper but will be presented in a further publication.

### Conclusions

Only a few of the general trends in Obstetrical practice, based on a study of

21,005 deliveries in Saint Joseph Infirmary, have been outlined and discussed. This study further supports our convictions, that the principles and practices of modern obstetrical care are basically sound. Further decrease in the maternal morbidity and mortality rates, and an increase in the intrauterine and neonatal salvage rates will depend on:

1. The continued adoption and utilization of all therapeutic advances in scientific medicine.
2. The broadened application of the principles of Preventive Obstetrics (complete prenatal laboratory and clinical care.)
3. The expansion of hospital facilities so that modern equipment and consultation service is available to all physicians for their maternity cases.
4. The creation of a special department within the hospital for the specific care of the premature infant.
5. The continued education of the public to accept and demand modern scientific Obstetrical care.
6. The establishment of an unprejudiced committee to study all reported cases of maternal deaths and report their conclusions and recommendations annually.

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The new drug, streptomycin, has proved more effective than any other yet discovered in controlling progressive tuberculosis in the lungs and other organs of the body. There are certain limitations and disadvantages in its use, and it is not expected that streptomycin will replace conventional methods of treatment, such as bed rest and the mechanical measures, like pneumothorax, which selectively put diseased tissue at rest. It has appeared so promising, however, that its potentialities must be thoroughly explored. More money is being spent on streptomycin research in the United States today than on any other phase of tuber-

culosis research. Edmond R. Long, M. D., Chairman Comm. on Tuberc. Research, NTA.

There are two aspects to the educational problem (in tuberculosis). First, the getting of knowledge, which is not, after all, a very difficult thing to do. We perhaps are sometimes embarrassed by the knowledge we have. The knowledge which we have of tuberculosis is really enormous. The second aspect is the difficult problem: making this knowledge effective. There are three to educate, the public, the profession, and the patient. William Osler, M. D., Nat. Tuberc. A. Tr., 1905.

## DISAPPOINTMENTS FOLLOWING CHOLECYSTECTOMY

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The subject chosen for the title of this paper is one with which surgeon, internist, and general practitioner alike are familiar. The conscientious, honest, surgeon readily admits a certain percent of disappointing results or failures to obtain relief from symptoms after cholecystectomy, but he feels that the majority of these failures are preventable or curable. The referring physician is especially impressed by these failures or poor results attending some of our gall bladder surgery, since it is he who usually has the task of following these patients and administering therapy postoperatively. The patient who is not relieved by surgery naturally feels that the operation performed on him was a poor one and he makes this known to all his many friends. The result is that there is a prevalent opinion among the laity, as well as among a considerable portion of the medical profession, that gall bladder surgery is generally attended by poor results and that a patient who has had his gall bladder removed must of necessity follow a rigid diet and always be a semi-invalid from that time on.

### Merits of Cholecystectomy

We frequently encounter a patient who is hesitant about having a cholecystectomy because he has a friend who has obtained no relief or has even seemed to be made worse by the operation. The unfortunate part of this story is that it is so often true; however, such should not be the case and the fault is usually with the surgeon rather than with the operation when a poor result is obtained. The merits of cholecystectomy are emphasized in this discussion by presenting a brief review of the results being obtained in some of the leading clinics and by attempting to analyze the failures and determine the causes for these failures. In Rodney Maingot's book, "Abdominal Operations," we find the following statement: "The late results of cholecystectomy for chronic calculus cholecystitis show that in some 80% of cases the patients are cured, that in 15% there is considerable improvement, and that in 5% the patients will ex-

perience attacks of biliary colic with or without jaundice." A. O. Whipple<sup>7</sup> whose results are tabulated in the recent surgical reference book entitled "Surgical Treatment," by Bancroft and Wade, indicates that of 490 patients followed 420 showed complete symptomatic relief, or 85.7%. The British surgeon, J. B. Oldham<sup>8</sup>, writing in "British Surgical Practice," states that the mortality of cholecystectomy for chronic cholecystitis or gall stones varied from .5% to 3%. The late results show that 80% of patients are cured, some 15% are greatly improved, but have postoperative flatulence, chronic dyspepsia or even slight colic. R. L. Sanders<sup>10</sup>, of Memphis, discussing the gall bladder problem on the basis of a study of 3,000 private cases concluded that in properly selected cases approximately 90% of patients will be benefited by cholecystectomy. Sanders states that this applies not only to those with stones in the gall bladder and those with cholesterosis, but also to those who have a badly diseased non-calculus gall bladder.

### Results of Surgical Treatment

In a review of the results of surgical treatment in acute cholecystitis one encounters great variations among the statistics on operative mortality from the various clinics. Eliason and Stephens<sup>11</sup>, University of Pennsylvania, reported on 135 cases of acute cholecystitis in which after proper preparation early operation was performed with a mortality of 1.5%. These investigators used cholecystostomy in 68% and cholecystectomy in 32% of these cases. All the patients on whom cholecystectomy was done were cured and 84% of those having cholecystostomy were without symptoms at the last following. Marshall and Phillips<sup>12</sup>, of the Lahey Clinic, reported an operative mortality of 1.3% in a series of 74 operations for acute disease of the gall bladder. Cholecystectomy was accomplished in 73 of these cases and cholecystostomy in one. Maingot's<sup>2</sup> review of the literature on this subject indicates that the mortality from operation in acute cholecystitis varies from 2 to 10%. As will be brought out later, there are many reasons for the variations in operative mortality.



### Percentage of Cures

The percentage of cures in cholecystectomy for non-calculus cholecystitis is comparatively low. According to Oldham<sup>9</sup>, unsatisfactory results are obtained in at least 30% of the cases. Maingot's<sup>3</sup> results are even more discouraging; he states, "The results of removal of the gall bladder for non-calculus chronic cholecystitis are very disappointing. In my experience less than 25% of the patients subjected to this operation are symptom-free. The operative mortality rate may be .5% or less, but the morbidity rate is over 70%." Follow-up investigations by Graham and Mackey<sup>13</sup>, at the Barnes Hospital, in St. Louis, showed that about 35% of patients with a pathological, but non-calculus gall bladder who presented merely symptoms of dyspepsia remained unrelieved after cholecystectomy. Lehman<sup>15</sup> has found failures in 36% of his patients with non-calculus gall bladders. With these points in mind, we begin to formulate the opinion that cholecystectomy is an operation which gives very good results in properly selected cases, but may give very poor results under other circumstances. Since we know that the results from cholecystectomy are good in properly selected cases, it seems in order at this point to present a short resume of what constitutes a properly selected case. Consideration of the following indications and contraindications for cholecystectomy form the basis for proper selection of the patient for cholecystectomy.

### Indications For Cholecystectomy

1. Some cases of traumatic injury or rupture of the gall bladder.
2. Carcinoma of the gall bladder if no marked liver metastasis is present, and this often involves wedge excision of a portion of the liver.
3. Innocent or benign new growths of the gall bladder.
4. Most cases of internal or external biliary fistula and especially mucous fistula following cholecystostomy.
5. Cholecystitis with or without stones.
  - (a) Strawberry gall bladder.
  - (b) Mucocoele of the gall bladder due to a stone impacted in the neck of the gall bladder or cystic duct.
  - (c) Some cases of acute cholecystitis particularly those cases with definite diagnosis in which patient is seen in first 48 hours.

- (d) Volvulus of the gall bladder.
- (e) Empyema of the gall bladder.
- (f) Gangrene of the gall bladder.

### Contraindications For Cholecystectomy

1. Normal gall bladder.
2. The presence of peritonitis due to perforation of the gall bladder, or to the presence of an abscess around the gall bladder.
3. When it is impossible to identify the biliary passages and the all important blood vessels (very acute cholecystitis with extensive edema about the ducts).
4. When jaundice, due to stone in the common duct, is associated with acute cholecystitis (Maingot<sup>4</sup>).
5. A distended gall bladder and a common duct without stones due to obstruction in the common duct or ampulla (Vaughn<sup>16</sup>).
6. Poor general condition of the patient (renal disease, heart disease, pancreatitis, or pulmonary lesions, and extreme obesity).
7. Intrahepatic calculi are also a contraindication to cholecystectomy, for this condition is one in which stones pass down the hepatic and common ducts repeatedly (Lichtman<sup>17</sup>).
8. The gall bladder, though filled with stones, should be saved if possible in cases of advanced cirrhosis of the liver for it may be needed for adequate drainage of bile (Mentzer<sup>18</sup>).

A certain amount of repetition necessarily accompanies a discussion of this type. One cannot expect to obtain good results with cholecystectomy unless he adheres to the indications and avoids the contraindications to the procedure.

### The So-Called Post Cholecystectomy Syndrome

Even though the operation of cholecystectomy is performed on a properly selected patient a certain number will show persistence of symptoms following the operation. The term postcholecystectomy syndrome is frequently used to signify that entity in which the symptoms persist following cholecystectomy. A discussion of the possible causes of this syndrome will cover the reasons for most of our disappointing results in gall bladder surgery. These include:

1. Erroneous preoperative diagnosis.
2. Calculi in the biliary duct.

3. Common duct stricture.
4. Stone or inflammation in the cystic duct remnant.
5. Adhesions involving the stomach or duodenum.
6. Residual cholangitis, hepatitis, and pancreatitis.
7. Removal of the functioning gall bladder.
8. Biliary dyssynergia, or dyskinesia.
9. Unrecognized malignant lesions.

#### **Erroneous Preoperative Diagnosis**

This is, perhaps, the most frequent cause of postcholecystectomy complaints. In many of these cases the patient did not give a history of typical biliary colic and the operation was performed without sufficient evidence of gall bladder disease. It is a great temptation for us to study the neurotic patient who complains of vague abdominal discomfort and gas on her stomach, probably due to the fact that she is an air-swallower, and if the X-ray shows non-visualization or poor function of the gall bladder to recommend surgical removal of the organ. The appearance of the gall bladder at operation in these cases often approaches normal and the complaints postoperatively are the same or worse than they were before operation. Bockus<sup>19</sup> states, "Operation should never be advised in the presence of a neurosis unless the pain is typical and the laboratory studies incriminating the gall bladder are irrefutable. Pyloroduodenal irritability, gastro-intestinal hypermotility, and colonic dysfunction are much more frequent causes of symptoms in these patients than is gall bladder disease. Peptic ulcer may be erroneously diagnosed as cholecystitis, although the experienced historian will rarely make this mistake. Less frequently, hiatus hernia, pancreatic calculi, coronary heart disease and diseases of kidney and the ureter are missed and the gall bladder is thought to have been responsible for the complaints. Parietal abdominal neuralgia, another not infrequent cause for pain in the right hypercondrium, has also been confused with gall bladder disease."

#### **Calculi in the Biliary Ducts**

The incidence of choledocholithiasis in patients operated for biliary tract disease averages about 10% in the case of acute cholecystitis and 13% in chronic cholecystitis (Berk). It is of interest to note that there is an increasing tendency over

the country to explore the common duct with a resulting increase in the incidence of common duct stones reported. At the present time, the Lahey Clinic group<sup>21</sup> explore the common duct in 45-7% of all patients with cholelithiasis and the incidence of common duct stones has risen to 16.8%. The difficulties of common duct exploration are generally appreciated by the abdominal surgeon and it is common knowledge that even in the hands of the most experienced surgeons stones are overlooked in approximately 15% of the cases in which the duct is explored. As suggested above, there is some difference of opinion concerning indications for opening the common bile duct and some surgeons open many more than others do under similar circumstances. The generally accepted indications for exploration of the common bile duct are:

1. Jaundice.
2. Dilated or thickened common bile duct.
3. Small stones in the gall bladder (especially if the cystic duct is normal or larger than normal).
4. Positive or suspicious findings on palpation.
5. A sediment in bile aspirated from the common duct.
6. Acute or sub-acute pancreatitis.
7. Non-calculus gall bladder with biliary tract symptoms.

#### **Common Duct Stricture**

Stricture of the bile duct is a subject upon which one could write a textbook. In a presentation of this type, it will suffice to say that such a stricture is practically always the result of a surgical error which was preventable. It is usually produced by accidental ligation or clamping of the duct, excision of a portion of it, or destruction of its blood supply so that it becomes necrotic and replaced by scar tissue. The clinical manifestations of common duct stricture may be those of an immediate postoperative occlusion in which the patient develops jaundice within 12 to 48 hours and it is progressive and fatal in a relatively short period of time unless re-operation is undertaken for release of the obstruction or a spontaneous biliary fistula is established. Other manifestations of common duct stricture are a persistence of external biliary fistula and the appearance of an obstructive jaundice developing late after operation. The external biliary fistula is characterized by



persistence of copious drainage of bile from the sinus tract after the removal of a T tube from the duct. In the case of the obstructive jaundice developing some time after operation, the stricture may be the result of a progressive contraction of scar tissue from trauma or a combination of the effect of trauma and super-imposed infection. The treatment of stricture of the common bile duct resolves itself into re-establishment of the biliary flow either by anastomosing the ends of the common bile duct or by anastomosing the duct to some portion of the gastro-intestinal tract. This is very complex surgery and cannot be dealt with at length in a presentation of this type. The seriousness of common duct stricture is emphasized by Main-got's<sup>5</sup> remark: "About 30% of the patients who have sustained injuries of the bile ducts during cholecystectomy die of the immediate consequences of such an injury, another 30% succumb from the operative interference necessary for its repair, and although 40% make good immediate recoveries after such interference, they are liable to recurrence of biliary disease, especially obstruction with suppurative cholangitis, which eventually proves fatal." Prevention is the secret to success in common bile duct stricture.

#### **Stone or Inflammation of the Cystic Duct Remnant**

It is a generally accepted fact that leaving too long a cystic duct remnant may lead to future trouble. Hicken, White, and Corey<sup>22</sup> reported 29 cases in which patients were re-operated for the removal of the diseased cystic duct which should have been removed during the first operation. These authors state that in 27 of their cases, the operation was performed by men who operated only occasionally and whose fear of injuring the common duct compelled them to be overly conservative. Such a cystic duct remnant may become dilated to form a "new gall bladder." One occasionally observes the formations of stones within the so-called "new gall bladder." The symptoms in such cases are essentially the same as before the original operation. The author has one patient who was originally thought to be a neurotic who was relieved by removal of such a cystic duct remnant without stones and has remained symptom free so far as this condition is concerned for fourteen months.

#### **Adhesions Involving the Duodenum or Stomach**

At times upper abdominal discomfort following cholecystectomy is dependent upon fixation of the duodenum to the under-surface of the liver at the site of extirpation of the gall bladder. This may produce marked angulation and distortion of the duodenum and pyloric end of the stomach. In these patients the symptoms usually do not simulate gall bladder disease, but may cause confusion because of their similarity to peptic ulcer symptoms.

#### **Hepatitis, Cholangitis, and Pancreatitis**

These lesions are often termed the residues of cholecystic disease. According to Bockus<sup>19</sup>, it is probable that their frequency has been over-emphasized in discussions of postcholecystectomy syndrome. If jaundice has antedated operation, residual inflammation of the hepatobiliary system and pancreas must always be considered in the diagnosis. Liver function tests, non-surgical biliary drainage, and a study of the principal functions of the pancreas may prove of help in the diagnosis. If the postoperative complaint is severe acute pain, acute pancreatitis should be considered. Serum amylase tests and an investigation of carbohydrate metabolism should be ordered in all such cases.

#### **Removal of the Functioning Gall Bladder**

The normal gall bladder has already been listed as a contraindication to cholecystectomy and we dismiss this as something everyone should know; however, when one visits the operating rooms at the various hospitals he will not infrequently see a perfectly normal gall bladder being removed. One should be very careful in making a diagnosis of gall bladder disease and as previously implied, the results will be much better generally if the surgeon will make an effort to operate only upon patients with gall stones. The clinician should be especially careful to be sure that the gall bladder is non-functioning because there is disease present and not because there is something wrong with his X-ray technique.

#### **Biliary Dyssynergia**

All of us are familiar with the syndrome described as biliary dyssynergia or dyskinesia which is supposedly due to spasm of the sphincter of Oddi. This syndrome should be given serious consideration in

the diagnosis of postcholecystectomy symptoms if:

1. The pain is similar in location and character to that of a calculus colic, but is of shorter duration.
2. The attacks occur with great frequency—often several times daily.
3. Recurrence of symptoms has been related to anxiety, tension or other psychic unrest.
4. The individual attack is relieved promptly by inhalation of amyl nitrate or the sublingual application of 1/100 gr. of nitroglycerine.
5. A similar attack can be brought on by the injection of 1/6 gr. of morphine.
6. The pain attacks are not accompanied or followed by jaundice, chills or fever.

Of equal importance is the ability to obtain a history of other complaints from the patient which suggests the prior existence of symptoms of neurogenic origin, i. e., transient cardiospasm, peptic ulcer-like symptoms without objective evidence of ulcer, irritable colon, and emotional diarrhea.

### Complications

Some of the most bitter disappointments attending gall bladder surgery are the result of the complications which may produce death in the immediate postoperative period or after a longer interval. If such complications do not produce an early death they not infrequently make a permanent invalid of the patient who then leads a miserable existence and finally succumbs to the effects of the operation. These complications are:

1. Hemorrhage.
2. Postoperative shock.
3. Biliary peritonitis.
4. Hepatic or renal insufficiency.
5. Cholangitis.
6. Postoperative adhesions, pyloric and duodenal.
7. Common duct stricture.
8. External biliary fistula.
9. Pulmonary complications.
10. Cardiac complications.

### Hemorrhage

An alarming hemorrhage may be encountered during the operative procedure of cholecystectomy as a result of accidental severance of the cystic artery or of having a clamp slip off of this artery. Attempts to control such hemorrhage by blind application of clamps in the blood filled field is one of the most frequent

causes of damage to the common bile duct and other vital structures in this region. In such an emergency, the operator should go to the left side of the table where he can work much better, and insert his index finger into the foramen of Winslow, in order to compress the hepatic artery between the finger and thumb. This will control the bleeding until he can explore the area, find the cut end of the cystic artery and tie it.

### Postoperative Shock

The improvements in supportive therapy during the past few years have greatly reduced the instance of postoperative shock. This complication should be unusual in the average cholecystectomy for chronic cholecystitis with stones which is done as an elective operation. Shock is more apt to occur in the patients with acute cholecystitis, and even in these cases careful surgical technique and the administration of plenty of blood and fluids will eliminate any very marked degree of shock in most instances.

### Biliary Peritonitis

Postoperative biliary peritonitis is a very serious and frequently fatal complication. It may be due to the escape of bile into the peritoneal cavity as a result of an insecurely ligated cystic duct to an oozing from accessory bile ducts which were not ligated, or to an oozing of bile from the gall bladder fossa. This complication will be very infrequent if drainage is carried out in all cholecystectomies and it is our practice to place one or two Penrose drains down to the foramen of Winslow and bring them out through a lateral subcostal stab wound at the completion of all cholecystectomies.

### Hepato-Renal Syndrome

A very dreaded complication of biliary tract surgery is that of hepatic and renal insufficiency. Excellent articles have been published on this subject by Boyce and McFetridge<sup>23</sup>, of New Orleans, and Garlock and Klein<sup>24</sup>, of New York. Two general types of liver death are described. In the first of these, the patient shows a delayed recovery from the anesthetic followed by a semi-comatose condition and a progressively rising temperature which often reaches 106 to 107 degrees and is accompanied by muscular twitching, coma, and death within 24 to 48 hours. This complication may be seen in patients who were considered to be relatively good



risks for surgery preoperatively and autopsies on this type patient give little information as to the cause of death. In most instances all the organs are essentially normal. The second type of liver death is a more gradual thing in which the patient recovers from the anesthetic and goes several days; then, begins to run an elevated temperature and show a gradual diminution in the urinary output, and finally goes on to death from uremia in 10 to 14 days. Boyce and McFetridge<sup>23</sup> believe that this is simply a delayed manifestation of the usually promptly fatal complication accompanied by marked hyperpyrexia.

Cholangitis is usually not a complication of cholecystectomy unless there is a postoperative obstruction in the biliary system and drainage of the bile from the liver is interfered with. It is most often a residual of preoperative disease.

As indicated above, adhesions between the pylorus and duodenum and the under-surface of the liver may give rise to persistent symptoms after cholecystectomy. We should bear in mind, however, that adhesions in the abdominal cavity do not produce nearly as many symptoms as they get the blame for.

#### Common Duct Stricture

Stricture of the common bile duct has already been discussed and is repeated only to emphasize what a terrible tragedy injury to the bile duct really is and to stress again that prevention is the only really satisfactory treatment. Such strictures will be infrequent if the operating surgeon has adequate exposure, a good light, and the proper knowledge of the anatomy in the gall bladder and bile duct region.

#### External Biliary Fistula

A persistent external biliary fistula is the result of an obstruction distal to an opening in the biliary tract, for example, an obstruction below the site of drainage in choledochostomy will give rise to a draining fistula. Likewise, a stone in the common bile duct overlooked at the time of cholecystectomy might be responsible for the tie coming off of the cystic duct with resulting bile drainage and fistula formation. Such fistulae require additional surgery in most instances and it is of a complicated variety.

#### Pulmonary Complications

Gall bladder surgery is accompanied by the usual complications of upper abdominal surgery. Atelectasis may occur within

the first 48 or 72 hours after operation or a pneumonia may appear at a later date. These complications are also on the decline with better postoperative care.

#### Cardiac Complications

These complications which include cardiac insufficiency, coronary thrombosis, and others will also be infrequent if the patient's status is properly evaluated before surgery is done and the surgeon works in cooperation with the internist in caring for the patient pre- and postoperatively.

One is very much interested to read the report given in Maingot's book, in which he states that fully one-half of the deaths which follow operations upon the biliary tract are caused by cholemia, the remainder are due to hemorrhage, peritonitis and chest complications. He states that the death rate following operation upon the biliary tract depends largely upon the presence of complicating factors and errors in the operative technique.

The subject of cholecystectomy is reviewed with special reference to the results being obtained with the operation, the possible causes of failure, including, a discussion of the so-called postcholecystectomy syndrome and the complications. Suggestions for improvements of results are included.

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## A TRIBUTE TO OSCAR O. MILLER

It is seldom that a member of a medical association is called upon for such extended laborious service as our association has asked Oscar O. Miller to perform. He was appointed as the first Chairman of the Committee to Study Plans for Prepayment of Medical Care in 1945.

When Dr. Miller entered upon this duty, such plans were comparatively new and were not perfectly understood. First there was the task of studying those plans in existence and attempting to develop one suitable for Kentucky. Then it was necessary to enact legislation permitting the formation of such a plan. After all this was done and the first corporation was formed, due to technical reasons it became necessary to re-incorporate.

The way has not always been easy and the plan that Dr. Miller has carried to fruition has required capable leadership and intelligent management. He has exhibited these qualities over and over and has led his group through many obstacles.

Dr. Miller has given six years of hard work to this phase of the Association's activity because of his sincere belief in the people's need for the plan and because of its importance to the profession. He was convinced that the increased cost of medical care which has been the inevitable result of increased quality of medical care must be cushioned for persons in low income groups. He felt that the medical profession had an obligation to take the lead in answering this medical problem.



In most of the areas of life the individual can supply his needs in accordance with his ability to pay. The quality of food, shelter and clothing varies with family income. Although this principle is accepted in these areas, it affords a poor answer for making good medical care available to our people.

The nations of the world have tried to answer the problem in their own way. Communistic and socialistic nations have established communistic and socialistic systems of medical care. This is logical and is to be expected. A people naturally turns to the ideologies to which its faith is pinned for the answers to its problems.

To Dr. Miller and others like him, a socialistic plan in democratic America

was anathema and he did his part in stemming the tide that threatened to engulf the profession.

As he relinquishes the presidency upon his own request, Dr. Miller would be the first to say that all of the credit for Kentucky's rapidly growing Blue Shield Plan does not belong to him. He would share with his colleagues that went along the way with him. Dr. B. B. Baughman, who succeeds Dr. Miller as President, was one of them, and there were several other faithful ones who bore much of the burden.

The physicians of Kentucky and the people of Kentucky owe a debt of gratitude to Dr. Miller for his efforts in their behalf.

## B. B. BAUGHMAN ELECTED HEAD OF KENTUCKY PHYSICIANS MUTUAL, INC.

At the Annual Meeting of the Board of Directors held on December 19, B. B. Baughman, Frankfort, was elected President of Kentucky Physicians Mutual, Inc., to succeed Oscar O. Miller. Dr. Baughman had previously served as Vice President.

Other officers elected were E. C. Yates, Lexington, Vice President; Bruce Underwood, Louisville, Secretary-Treasurer. Mr. D. Lane Tynes was appointed Executive Director and Mr. Raymond F. Dixon, Assistant Secretary-Treasurer.

At the Annual Meeting of the Members held on October 19, 1950, Doctors Oscar O. Miller, Louisville; J. Vernon Pace, Paducah; Walter L. O'Nan, Henderson; Samuel E. Paris, Bowling Green; William H. Cartmell, Maysville; Ralph W. Allen, Pikeville; Edgar S. Weaver, Carrollton; Messrs. W. Emmet Milward, Lexington, and H. J. Fenton, Murray, were elected to serve as directors for terms of three years. The board has 27 members, 22 of whom are physicians.

The following committees were appointed by the board of directors:

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Upon the shoulders of these officers and directors rests much responsibility. Kentucky's Blue Shield Plan during little more than one year's active operation has developed into a state-wide organization. Almost 50,000 Kentuckians now participate in the Kentucky doctors' plan for helping the lower income group meet the costs of medical care.

Since Kentucky Physicians Mutual, Inc., is sponsored by, and is an offspring of, our State Medical Association all members of the association owe their loyalty, allegiance, and active support to the officers and directors who are carrying on this program which is so important to the medical profession in Kentucky.

The first duty of each physician is to become a participating physician in the plan. His second duty is to assist in enrollment campaigns by explaining the plan to patients and employers. The third duty is to develop an active interest in the plan to protect it from abuses.

In their own interest and on behalf of the people, it is imperative that physicians encourage all legitimate types of medical care insurance and particularly our own Blue Shield Plan.

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## A. M. A. URGES FEDERAL HEALTH AGENCY

The American Medical Association has long favored the establishment of a Federal Department of Health with cabinet status. Point 1 of the A. M. A. twelve-point program reads as follows:

"Creation of a Federal Department of Health of cabinet status with a secretary who is a doctor of medicine, and the coordination and integration of all Federal health activities under this department, except for the military activities of the medical services of the Armed Forces."

Acting in the belief that the time is ripe to achieve success in this regard, Kentucky's delegation to the A. M. A. House of Delegates introduced a resolution calling for the establishment of a Federal Department of Health whose head would be a physician and a member of the cabinet. The resolution also proposed a Federal Board of Health, permitting the medical profession rather than laymen to guide governmental health activities.

The Reference Committee on Legislation, to which the resolution was referred, following testimony and deliberation by various officers, delegates and members of the Association, reached the conclusion that such a department with cabinet rank is not attainable at the present time. The Committee proposed a substitute motion, which follows:

"RESOLVED, That the House of Delegates

of the American Medical Association urges all officers and members of the American Medical Association and all constituent associations to take immediate steps to implement the passage into law of a bill providing for the coordination and integration of all federal health activities under an independent agency with executive status except the medical services of the armed forces and of the Veterans Administration."

The resolution was passed by the House of Delegates.

There are many advantages in the agency being of executive status rather than of cabinet status. It would come under civil service which would protect it from much political domination. It would be of equal rank with the Federal Security Agency, which is headed by Oscar Ewing, and which contains a hodgepodge of unrelated activities including the U. S. Public Health Service. It would permit an advisory council of physicians to guide its actions.

The proposed Health Agency would administer all of the health programs of the Federal government, with the exception of the medical services of the armed forces and the Veterans Administration. This is in keeping with the Hoover Committee recommendations. At present health activities are combined with many other



governmental functions such as Welfare and Education. They are administered by laymen whose chief interests lie in other fields. There is much duplication of effort and there are no clear cut over-all policies delineating the government's place in the health field.

Your representatives feel that all of the desirable objectives of a Department of Health cabinet status can be achieved in

a Health Agency of executive status and are happy to have had a part in this important action of the American Medical Association. Delegates of other state associations were enthusiastic concerning the resolution and the Kentucky delegation received many congratulations for their successful efforts in implementing this objective.

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## A. M. A. HOLDS IMPRESSIVE SESSION AT CLEVELAND

Those who attended the House of Delegates, Public Relations Conference and all the meetings held in connection with the A.M.A. Clinical Session at Cleveland, December 3 to 8, were strongly impressed by the practical, concentrated and humanitarian effort directed toward the solving of the problems before the profession today.

While Medicine had won a great battle in the November 7, 1950, elections, it was far from winning the war against socialism in this country—that this was certainly not the hour to relax in our efforts in the fight, but that it was the time to lend the greatest possible assistance to carrying out a constructive, energetic and humanitarian program.

Roundly condemned were the relative few physicians who overcharged for professional services, split fees, refused night and holiday calls, and whose misdeeds discredited our honorable profession.

Having won a defensive battle in November, professional leaders at the Meeting seemed to be in complete accord with the idea that from now on our fight should

employ such positive implements of warfare as vigorously seeking to extend voluntary health insurance coverage, establishing emergency call service, disciplining our own members, promoting rural health and actively supporting public health.

The attitude of the attendants was obviously one of determination to take the offensive in the war on socialism through constructive, humanitarian methods. There was a feeling of sincere gratefulness for the large number of new friends who were willing to "Stand up and be counted" on November 7, and to conclusively demonstrate to those new friends our desire to merit their continued support.

We believe members of the Kentucky State Medical Association will find the above principles, attitudes and aims in thorough harmony with their own thinking, and that we all will move out in a humble, purposeful manner to bring honor to the profession that has been so generous to us—and serve more conscientiously our patients who have made us what we are.

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## EDITORIAL COMMENTS

**Commander Aaron A. Shafer, formerly of Louisville and presently of the U. S. Navy, has forwarded us an article from "The Nippon Times," a Tokyo newspaper, telling of the sad straits in which the Japanese government health insurance plan finds itself.**

The article frankly calls the National Health Insurance scheme "socialized medicine," and says that it is financially ill. Only 67 percent of premiums due were collected and 4,200 million yen are in arrears. The Japanese government

made an emergency appropriation of 3,000 million yen to meet part of the deficit.

Due to the deficiency, doctors are having to wait for their pay and are pinched for money. The writer asserts that some doctors, presumably to increase fees and to cover the delay in payment, give costly medicines and injections to patients with minor illnesses.

Here we see two prophecies made pertaining to U. S. A. Compulsory Health Insurance coming true in Japan—tremendous cost and inevitable deterioration of



the medical profession.

We do not see how the doctors found the time for many additional treatments, however, since records show that more than half of all Japanese policy holders presented themselves for some kind of medical care during the month of July, indicating much abuse of the plan.

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**A. M. A. President Elmer L. Henderson's** President's Page, a new feature of the A. M. A. Journal, is receiving much favorable comment.

We recently noted an editorial in the New York State Journal of Medicine, congratulating Dr. Henderson on this endeavor to keep the membership informed as to what is taking place in the parent body of organized medicine.

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**The U. S. maternal death rate in 1949** reached a new all-time low of slightly under one per 1000 live births. In 1948 the rate was 1.2 and in 1933 there were 6.2 maternal deaths per 1000 live births in the United States.

The rate in Kentucky in 1949 was 1.3; in 1948, 1.5; and in 1933, 5.2.

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**We hope that Dr. T. Ashby Woodson,** Louisville, will accept our sincere apologies in completely omitting, in our editorial on The Kentucky Chapter of the American College of Chest Physicians, the fact that he is Governor of the College of Kentucky. In this capacity Dr. Woodson passes on the qualifications of candidates for membership and is required to keep in close contact with the activities of The Kentucky Chapter of the College.

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**Kentucky's new Governor, Lawrence W. Wetherby,** comes from a family of doctors. His father and his brother were physicians, both of whom practiced in Middletown. He also has two uncles and one cousin who are physicians; another cousin is now in medical school. In addition, Governor Wetherby married the daughter of a doctor of medicine.

In his inaugural address he expressed his interest in health conditions in Kentucky, particularly in the care of the mentally ill in state institutions.

We prophesy that Governor Wetherby will look with sympathetic understanding upon our problems, and in him the medi-

cal profession in Kentucky will have a friend.

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**The Eleventh Annual Essay Contest** of the Mississippi Valley Medical Society will be held in 1951. The Society will offer a cash prize of \$100.00, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics and education) and practical value to the general practitioner of medicine. The winner will be invited to present his contribution before the Sixteenth Annual Meeting of the Mississippi Valley Medical Society to be held in Peoria, Ill., Sept. 19, 20, 21, 1951. We will be glad to furnish further details upon request.

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**The American College of Surgeons** in a recent news release states that irregardless of the furore concerning the Hospital Standardization Program that at no time has the College decided to abandon the program and no overtures have been made to any other organization regarding its disposal.

The release continues, "The Regents have every intention of continuing the program, upon an expanded scale and even with deficit financing, until a solution can be found which is agreeable to the majority of the profession and which is, above all, in the best interests of the public."

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**The effect of the advent of sulfa drugs,** penicillin, and aureomycin on the death rate from pneumonia is dramatically shown in a chart in the September Statistical Bulletin of the Metropolitan Life Insurance Company.

In 1936, when the sulfa drugs were introduced, the chart shows the death rate to have been 59 per 100,000. The rate fell to 22 by 1945, when penicillin came into wide-spread use. In 1948, when aureomycin appeared on the scene, the rate was further reduced to 15. In 1949, there were only 13 deaths per 100,000 in the Metropolitan group, and it is expected to reach even lower levels when the newer antibiotics attain greater usage. To some extent, the downward trend of the death rate was considered to be due to more successful control of minor respiratory diseases, which often precede and may predispose to pneumonia.

# ORGANIZATION SECTION

## COUNTY SOCIETY OFFICERS TO HEAR FOUR NATIONALLY-KNOWN SPEAKERS

### Program for March 1 Meeting Outlined

Two A. M. A. leaders and two nationally-known state secretaries will be the featured speakers at the First Annual County Society Officers Conference, to be sponsored by the Association in an all-day meeting, Thursday, March 1, 1951, at the Brown Hotel in Louisville.

Elmer L. Henderson, M. D., Louisville, A. M. A. President, will bring greetings from the national organization. George F. Lull, M. D., Chicago, Secretary and General Manager of the A. M. A., will be at the luncheon.

Executive Secretaries Charles Nelson of Ohio and Ray Smith of Indiana will appear on the program. Both of these men have distinguished themselves through their excellent work with their respective state associations, and are in great demand as speakers.

Sam A. Overstreet, M. D., Louisville, President of the Association; C. C. Howard, M. D., Glasgow, Chairman of the Council; and Bruce Underwood, M. D., Louisville, Secretary and General Manager, will have important messages.

You will want to hear A. Clayton McCarty, M. D., Louisville, Chairman of the Kentucky Procurement Committee for Military Service, and R. Haynes Barr, M. D., Owensboro, Chairman of the Education Campaign Subcommittee, give the latest plans of their respective committees.

Other features of the meeting will be two discussion periods, where attendants will have an opportunity to "stump the experts." There will be a period for Councilor District conferences, which will enable each Councilor to meet the county society officers of his district and plan for the coming year.

Every county society officer, the chairman of the county Legislative and Public Relations Committee, every Councilor, every state officer, and chairman of every K. S. M. A. committee is invited to attend this meeting. It will be one of the "high spots" of the year in Kentucky medicine.

### Members Urged to Cooperate With Local Society Secretary

The Garrard County Medical Society was the first county society to report its 1951 officers and collection of K.S.M.A. dues. Congratulations

to the good physicians at Lancaster.

The county medical society officer is one of the basic cogs in the wheel of the entire medical organization. When he does his job properly, much time, energy and planning are involved. He deserves your cooperation and support.

Individual members will be doing the local county society secretary a real service, saving him much time and helping him to serve you better, by remitting local, state and A. M. A. dues at the earliest possible date.

### Labor Leader Condemns Socialization of Medicine at A. M. A.

The most dramatic event of the entire A.M.A. Cleveland Clinical Session came when the address of William L. Hutcheson, General President of the United Brotherhood of Carpenters and Joiners of America, was presented to a joint meeting of the House of Delegates and the Third Annual Educational Conference in the Grand Ball Room of the Statler Hotel over a national radio hook-up, Thursday afternoon, December 7, 1950.

"Socialized Medicine is no Bargain," was the title of the address of the prominent labor leader who stated he and his organization opposed socialized medicine. He said, "It looks cheap the way the backers present it, but when you dig down under the fancy layer of propaganda frosting you find that it can be mighty expensive."

Calling attention to the operation of socialization of medicine in England, Mr. Hutcheson pointed out that while it was estimated the "system" would cost 167 million pounds, it was now actually costing 484 million pounds, and the end is not yet in sight. "By my old-fashioned arithmetic, that is an increase of better than 345 per cent, and I am sure my poor old mother, who always made a dime do the work of a quarter, would not consider that kind of a proposition a bargain."

"Socialism and death have one thing in common; you cannot be a little bit socialized or a little bit dead. It is either whole hog or nothing," he continued. He pointed out that Carpenters were an independent lot, and wanted to work when and where they pleased. He went on with "the first bureaucrat who told a carpenter he had to work in Little Rock when he wanted to work in Lancaster would be gum-



ming his food for the lack of teeth."

Saluting the physicians as crusading citizens, willing to fight for their convictions, Mr. Hutcheson concluded with "We in the labor movement have our own cross of regimentation to bear. The fight you are making is a part of the same war. It is a war against concentration of authority in a few hands in Washington. As a veteran of 40 years in the labor movement, I know what it is to fight for human rights. I am happy to take my stand beside you."

### **A. M. A. Trustees Vote \$500,000 Fund For Medical Education**

In a special session of the House of Delegates December 6 at the A.M.A. Clinical Session in Cleveland, Louis A. Bauer, M. D., Chairman of the A.M.A. Board of Trustees, announced the half-million dollar endowment "to be used without strings," which the Trustees had unanimously voted to medical schools as the A. M. A.'s contribution to a nation-wide fund to be raised from non-political funds.

The action followed the challenge made by A.M.A. President Elmer L. Henderson, M. D., Louisville, in his address opening the first meeting of the House of Delegates the day before. Recognizing the financial difficulties of the medical schools Dr. Henderson said the A. M. A. was very concerned about medical education. He reminded the delegates of the dangers of government aid and stated the A. M. A. believed funds could and would come from non-political sources to meet the needs of the medical schools.

"American medicine feels very strongly that it should not seek federal aid for medical schools until all other means of financing have been exhausted," said Dr. Bauer. "The Board of Trustees announced its belief yesterday that funds for this purpose could be obtained from private sources—and as practical evidence of our sincerity of purpose, this appropriation has been made as the nucleus of a fund which we hope will be augmented by contributions from many other sources."

The half-million dollar allotment to medical schools was taken from National Education Campaign Funds. Dr. Bauer said because of the outstanding progress made by the Campaign, it was possible to make this appropriation.

This money given the schools is in addition to \$285,000 that has been set aside for 1951, which the A.M.A. annually spends through its Council on Medical Education and Hospitals and other departments to advance medical education, an announcement said.

### **Physician Procurement Discussed by Top Officials at Cleveland**

Questions pertaining to the drafting of physicians were discussed at an informal meeting sponsored by the Council on National Emergency Medical Service of the A.M.A. at the Clinical Session in Cleveland, December 4, 1950.

Paul A. Barton, M. D., Executive Secretary of the National Advisory Committee (of which Howard A. Rusk, M. D., is Chairman), and Colonel Richard E. Eanes, Medical Director of the Selective Service System, were present, along with top ranking officers from the departments of the Army, Air Force, Navy and Public Health Service.

At the time of this meeting, it was pointed out that no physician had been drafted. Over 900 doctors of the 13,000 who registered under Priority I and Priority II have indicated a desire for a commission. Selective Service has classified over half of this registration.

The Army, it was reported, had 570 physicians in its medical service who had been borrowed from the Navy. Under plans then in operation, the Army expects to procure 1729 physicians by July 1. During this time, it is thought that the men borrowed from the Navy could be returned and replaced by new medical officers taken into the Army.

It was explained that conditions abroad were changing so rapidly that it was impossible to be very definite about the future requirements of the Armed Forces at this time. All plans for procurement of physicians by the Armed Forces are subject to immediate revision.

According to information received from the State Headquarters Selective Service, 162 Kentucky physicians registered on October 16. In Priority I, 118 were registered and in Priority II, 44. At the time this was written, the President had not set the date for registration of physicians in Priority III and Priority IV.

### **County Medical Societies Praised at Annual P-R Conference**

County medical societies were praised for their cooperation and efforts in behalf of public relations on all levels, by Elmer L. Henderson, M. D., Louisville, in a brief address at the banquet of the Third Annual Public Relations Conference of the A.M.A., December 3, 1950, in Cleveland.

Among other things, the A.M.A. President complimented the county medical societies of the nation for their cooperation on the tie-in-advertising, National Education Campaign, night and day emergency call service, promot-



ing health insurance and in every way in which they serve the cause of health.

Despite the progress made in the past two years, and in spite of the fact that the November 7 elections have driven the social planners underground temporarily, Dr. Henderson said that the threat of socialism is still very much with us, and the quickest way to dissipate the threat is to meet adequately the needs of the people, on the local level.

Louis B. Seltzer, editor of Ohio's largest newspaper, the "Cleveland Press," shared the speaking honors with Dr. Henderson, on the highly profitable program, and presented a well-received address on, "What the Community Expects of the Medical Profession."

### **Dr. Luce, Canton, Mass., Voted Gold G. P. Award For 1950**

Dean S. Luce, M. D., Canton, Massachusetts, was elected on the second ballot as the "General Practitioner of 1950" by the A.M.A. House of Delegates, in its first official action of the Cleveland Clinical Session, December 4, 1950.

Dr. Luce, aged 74, who has practiced at Canton since 1905, received the gold medal award at the December 6 meeting of the House of the Cleveland session, which was given "for exceptional service by a general practitioner." Dr. Luce was busy making his usual rounds at Canton when informed of the honor.

The new award winner feels that some doctors have provided arguments for socialized medicine advocates by their attitude on fees and night calls. He strongly opposes the proposals of the social planners. "If a man begins to count the dollars, he's making a failure of the practice of medicine," Dr. Luce says. "I never made a lot of money out of it and I never intend to."

John W. Strange, M. D., Loogootee, Indiana, father of Martin Strange, M. D., New Albany, Indiana, was runner-up for the honor. Andy Hall, M. D., of Mt. Vernon, Illinois, was the 1949 winner.

### **A. M. A. Education Conference Warned Goals Still to be Won**

"This is not the time to tear down the goal posts," A.M.A. President Elmer L. Henderson, M. D., told the Third Annual Conference of the National Education Campaign, meeting at Cleveland in joint session with the House of Delegates, Thursday, December 7, 1950, during the Clinical Session.

Acknowledging the dramatic gains made by the campaign in the past year and the favorable election returns, the Louisville leader warned his audience that, "Positive goals are

still to be accomplished and medicine must be ready for a new offensive from the "socializers." He pointed out the encouraging gains made in the 1946 elections, and the startling comeback the social planners made in 1948.

"We must keep our powder dry and avoid any relaxation in our resistance to the attacks of socialism on our American system," he said. He indicated that medicine had gained many new allies in the November 7 election, and urged the profession to express its appreciation locally and to strive to be even more worthy of their support.

Aims for the coming year of the campaign were listed as follows:

1. Establishment of maximum number of day and night emergency call bureaus.
2. Increase in rural health services.
3. Establishment of Grievance Committees.
4. Promotion of voluntary health insurance.
5. Promotion of Public Health Service in all of its aspects.

Louis H. Bauer, M. D., Chairman of the A. M. A. Board of Trustees, said that most of the bills before Congress at the time of the Conference would be re-introduced during the new Congress. He urged his audience to beware of fringe bills which the social planners would introduce in an effort to accomplish their aims through piecemeal legislation, and warned his hearers against complacency.

Leone Baxter, to whom Dr. Henderson, presiding officer of the Conference, referred as the "better half of the Whitaker and Baxter team," followed Dr. Bauer. Miss Baxter said that the recent A.M.A. advertising campaign saw the "greatest manifestation" of tie-in advertising cooperation ever carried out, when most of the support came from unrelated business, "up and down the 'Main Streets' of America." Almost twice as much money in tie-in advertising was paid for by other sources in the recent campaign as was spent by the A.M.A.

Clem Whitaker, of the advertising firm, told the Conference that the A.M.A. is in a stronger position than it has enjoyed for years, because the people have been given the facts. He stated that there is enlightened leadership in the labor movement which has no intention of following some of the politicians down the lane to socialism.

President-Elect John Cline, M. D., reviewed the results of the November 7, 1950, election. He indicated that medicine alone did not accomplish the favorable results and the profession should be duly grateful for the new friends in the fight to preserve the American Way. He pointed to the worthy goals ahead, and urged his hearers to even greater efforts to serve the public—"our patients."

### **Cleveland P-R Conference Called Best 375 in Attendance**

The Third Annual Public Relations Conference, sponsored by the A.M.A. in Cleveland, December 3 and 4, 1950, just prior to the Cleveland Clinical Session, was acclaimed the best and most profitable yet held.

Approximately 375 medical leaders from the United States and its territories attended the very full and enjoyable sessions arranged by Larry Rember, A.M.A. Public Relations Director.

Perhaps one of the most descriptive statements made on public relations came from the Monday morning monitor, who said, "Public relations is like making love. It is not satisfactory unless you do it yourself."

Elmer L. Henderson, M. D., Sam A. Overstreet, M. D., Bruce Underwood, M. D., and J. B. Lukins, M. D., all of Louisville, were among K.S.M.A. members attending.

Time and space of necessity limit the adequate reporting of the eminent session in the January organization section. We hope to present this material in part, in succeeding issues of this department.

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### **Kiwanis Honors Dr. Henderson**

Another honor has come to Kentucky's Elmer L. Henderson, M. D., the current President of the American and World Medical Associations, from Kiwanis International who has named 14 outstanding Americans who have "Come up the hard way."

Kiwanis has prepared a transcription series entitled, "The American Dream Come True," an interview with each of the fourteen individuals selected, which tells of the "rags to riches" saga of their success.

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### **A. M. A. Winter Meeting Attended by 16 K. S. M. A. Members**

Elmer L. Henderson, M. D., Louisville, A. M. A. President, led the three delegates and 12 other K.S.M.A. members to the well acclaimed Clinical Session and Public Relations Conference at Cleveland, December 3 to 8, 1950, which was attended by approximately 2,000 physicians.

Below we list those known to have attended the meeting. Information given below was obtained from the official registration.

Delegates: Clark Bailey, M. D., Harlan; J. B. Lukins, M. D., Louisville; and Bruce Underwood, M. D., Louisville.

Other K.S.M.A. members: Oscar Allen, M.D.,

Beaver Dam; Lt. Col. Herbert D. Edger, M.D., Fort Campbell; D. G. Miller, M. D., Morgantown; Alfred Glattauer, M. D., Brandenburg; Paul A. Robinson, M. D., Covington; M. O. Crowder, M. D., and Frank L. Yarbrough, M.D., Owensboro; M. M. Hall, M. D., and Roy G. Wilson, M. D., Campbellsville; Hunt Jones, M. D., Sam B. Maxwell, M. D., and Sam A. Overstreet, M. D., Louisville.

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### **Cooperation of Members at 1950 Meeting Pleases Exhibitors**

Your staff at the Headquarters office is very grateful for the response of the K.S.M.A. members to our efforts in seeking to have you visit and register with technical exhibitors, at the 1950 annual meeting.

Your cooperation this year and in the years ahead will go a long way in helping make our Annual Meeting one of the largest and best of the smaller Associations.

Our technical exhibitors were grateful for your interest and consideration. They were enthusiastic over your 30-minute recess during the scientific session. They were glad you wore your badges all the time you were in the building.

We want you to see some of the comments that were received from the technical exhibitors:

A representative of a publishing house said, "...One of the finest conducted meetings I have ever attended. I especially liked the large type on the badges."

A drug representative wrote, "Everyone was very cooperative, and the doctors were very responsive and showed more interest than ever before."

One representative sent us a copy of the report he sent to his company on our meeting. We quote excerpts: "We have just concluded a most successful exhibit....A great amount of thought and effort had been put into the convention...I would say the convention was worth our time, effort and expense; I hope we can make their 1951 Meeting."

A sales manager wrote us that his three representatives "have sent us some very enthusiastic reports....We have been told it was by far the best Kentucky Meeting held so far."

Another exhibitor wrote, "I especially want to compliment you on the various colored badges, the 30-minute recess and the announcements over the loud speakers."

A district manager wrote he had been averaging ten meetings a year for twenty years, but that "It has never been my pleasure to attend



a better planned, better supervised Meeting."

We are especially grateful for the report of the Traffic Committee of the Medical Exhibitors Association, Inc., (a national organization). The report opened as follows: "This year, the Kentucky Meeting was by far the best ever held in the state. It was handled in a manner equal to the best of the medical meetings, and several innovations were instituted."

### **S. M. A. Attracts 62 Kentucky M. D.'s Sixteen on Program**

Sixty-two Kentucky physicians attended the 44th Annual Meeting of the Southern Medical Association in St. Louis, November 13-16, 1950, which attracted a total registration of 3,524; of which 2,281 were physicians.

Sixteen Kentuckians were on the program. Twenty-nine of the doctors took their wives.

If we have missed giving the names of others present, we are sorry. Our information was taken from all available sources.

Kentuckians on the S.M.A. Program were: Rufus C. Alley, James T. McClellan and Francis M. Massie, Lexington; D. G. Miller, Jr., Morgantown; From Louisville—W. A. Askew, Herbert L. Clay, G. N. Combs, William R. Gray, M. Harcourt, Elmer L. Henderson, Jesshill Love, Charles T. Moran, James B. Rogers, Gracie R. Rowntree, Morris M. Weiss and Charles A. Woerner.

Other Kentuckians attending were: C. C. Barrett, William K. Massie, Jos. A. Stoeckinger and Delores M. Thompson, Lexington; Oscar T. Davis, James E. Hix, A. L. Kincheloe, W. L. Tyler and B. H. Warren, Owensboro; C. L. Combs and James Edward Hagan, Hazard; A. D. Butterworth, James C. Hart, Hugh L. Houston, and Conrad H. Jones, Murray.

Clifford N. Heisel, W. Vernon Lee, W. R. Miner, James A. Ryan, and Arthur J. Schwertman, Covington; Leon Higdon and J. Vernon Pace, Paducah; Lyman S. Hall and Michael M. Hall, Campbellsville; David L. Jones and Russell R. Rudd, Fulton; Wm. Seth Snyder, Jr., Frankfort; Wm. O. Carson, Bowling Green; Alfred Glattauer, Brandenburg; Harry A. Knauff, Wadsworth; M. L. Smith, Maceo; Kenneth L. Lockwood, Outwood; Samuel M. Rickman, Paris.

From Louisville—William Irvin Abell, Jr., J. C. Bell, W. W. Borsch, Sr., Michael R. Cronen, W. P. Eubank, Louis M. Foltz, E. R. Gernert, John Dunn Gordinier, Laman A. Gray, J. Duffy Hancock, John S. Harter, E. L. Henderson, Jr., W. O. Johnson, Robert Lich, Jr., Paul Mapother, Jennings B. Marshall, George F. McAuliffe, Oscar O. Miller, Robert F. Monroe, Wm. R. Moore, Carlisle Morse, Edward Ploetner, H. N.

Ritter, Marjorie Rowntree, Winston U. Rutledge, Allen M. Sakler, John H. Vonderbeck, Shelton Watkins, and A. David Willmoth.

### **New Members For November**

The Association welcomes the men listed below, who joined during the month of November, 1950:

Daviess, Frank L. Yarbrough, Owensboro; Campbell-Kenton, Louis J. Nutinni, Erlanger.

Fayette, William C. Robinson, Lexington.

Jefferson, William A. Blodgett, Louisville; William Christophersen, Louisville; Arthur H. Keeney (Assoc.) Philadelphia, Pa.; G. David McClure, Louisville; George C. Stege (Assoc.) Louisville.

### **Chest Physicians Sponsor Course**

A five-day postgraduate course, sponsored by the American College of Chest Physicians, will be held at Vanderbilt University in Nashville, January 22-27. Registration, according to the A.C. of C. P. announcement, is limited and a tuition of \$50.00 will be charged.

### **A. C. S. Initiates 10 Kentucky Surgeons**

Ten Kentucky Doctors have been admitted during 1950 to the American College of Surgeons, according to an official A.C.S. announcement.

They are: Winfrey Porter Blackburn, Frankfort; J. Ray Bryant, Louisville; Charles W. Caldwell, Jr., Danville; Morgan R. Colbert, Louisville; Marvin A. Lucas, Louisville; Jennings B. Marshall, Louisville; Joseph E. Maurer, Louisville; George H. Rodman, Greenville; George Arthur Sehlinger, Louisville; and Robert C. Tate, Louisville.

### **Industrial Congress to Meet at Atlanta**

The Eleventh Annual Congress of Industrial Health will be held at the Atlanta-Biltmore, Atlanta, Georgia, on February 26, 27 and 28, 1951. The theme of the Congress will be "Teamwork, the key to successful industrial health service."

### **Medical Service Group to Meet**

The National Conference of Medical Services will hold its 24th Annual Meeting in the Red Lacquer Room of the Palmer House in Chicago, February 11, 1951.

The meeting is of special importance to presidents, secretaries and public relations personnel of state and county medical societies.



### College of Surgeons to Meet Feb. 26-27

The American College of Surgeons has extended an invitation to the "members of the medical profession in Kentucky" to attend a two-day sectional meeting at Hot Springs, Virginia, February 26-27, 1951, through a statement by Claude C. Coleman, M. D., F.A.C.S., Chairman of the Committee on Arrangements. A five-dollar registration fee will be charged except from Fellows and members of the junior and senior candidates group of the college.

### Health Officers Oppose Compulsory Health Insurance

The Association of State and Territorial Health Officers again expressed its opposition to National Compulsory Health Insurance and once more voiced its demand for the creation of a Federal Department of Health with Cabinet status, according to Joseph S. Lawrence, M. D., head of the A.M.A. Washington office.

Meeting recently in Washington, the organization passed a resolution stating that National Health Insurance was unnecessary. The resolution called attention to progress made in preventive medicine, and protective sanitation against environmental hazards.

The work of organized health service was praised in the resolution, and it was pointed out, "It is generally recognized that the people of the United States now enjoy the highest standard of health of any country in the world."

Several hundred health officers representing every state and Canada, were present at the week-long meeting. Roy L. Cleere, M. D., of Colorado, is president of the organization.

### Offers Industrial Fellowship

The Institute of Industrial Health of the University of Cincinnati will accept applications for a limited number of Fellowships which are being offered to qualified candidates who wish to pursue a graduate course of instruction which will qualify them for the practice of Industrial Medicine.

The course of instruction consists of a two-year period of intense preliminary training in the basic phases of Industrial Medicine followed by one year of practical experience under adequate supervision in industry.

During the first two years, the stipends for the Fellowships vary from \$2,100 to \$3,000. In the third year the candidate will be compensated for his service by the industry in which he is completing his training. Requests for additional information should be addressed to the Institute of Industrial Medicine, College of Medicine, Cincinnati 19, Ohio.

### First District to Hear Discussion on Polio at Fulton, January 17

"Early Diagnosis of Poliomyelitis" will be discussed by Alex J. Steigman, M. D., Louisville, before the physicians and their wives at a dinner meeting of the First Councilor District, in Fulton, Wednesday, January 17, at 6:30 P. M.

J. G. Samuels, M. D., Hickman, will give the address of welcome. J. Vernon Pace, M. D., Paducah, First District Councilor, will introduce Dr. Steigman. Russell R. Rudd, M. D., Fulton, president of the host society, will preside.

### Schools To Increase M. D. Graduates By 450 In 1951

More than 6,000 seniors will graduate from the medical schools in June of 1951, which is about 450 more than finished in 1930, a survey of current enrollment conducted by Donald G. Anderson, M. D., Secretary of the A.M.A. Council on Medical Education and Hospitals, shows.

The total enrollment in all classes in the 1949-50 year was 25,103—an increase of 6% over the year before. Dr. Anderson expects an even larger number to attend in the 1950-51 academic year.

In the 1949-50 year the survey indicated that 7.2 per cent of the students were women and 65.9 per cent were veterans.

For the 1950-51 year the total budget for all schools amounts to \$67,500,000. In 1950, the University of Illinois School of Medicine graduated the largest number of seniors for a total of 161. Jefferson Medical College was second with 152.

### Industrial Health Group to Meet in Louisville, February 2

The first Conference on Industrial Health to be held in Kentucky, will be a dinner meeting at the Pendennis Club in Louisville, at 6:00 P. M., Friday, February 2, 1951.

The Conference is sponsored by industry, physicians, nurses, the Louisville Chamber of Commerce, Hygienists and others interested in industrial health. Four nationally known speakers will discuss the various aspects of health problems and health programs in industry.

Dinner reservations may be had by contacting Gracie R. Rowntree, M. D., Chairman of our K.S.M.A. Committee on Industrial Medicine and Surgery, at the Chamber of Commerce, Louisville. The cost of the dinner is \$4.50 per plate.

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## President's Page

Much effort and money has been expended lately by doctors, through the A. M. A. and our local societies, to present our viewpoint to the public and to enlist its understanding and cooperation in our problems. Many of our shortcomings have been aired. Collectively we have searched our souls, repented of our sins, and sought guidance toward a more productive and useful life. The time has now come for us to arise and go our respective ways in newness of life and a fresh consecration to service.

The conduct of each individual physician in his community and toward those who constitute his clientele will afford the best proof of the profession's earnest desire to better serve the public. To provide the best obtainable medical care to the greatest number of people at a cost commensurate with each one's ability to pay should be our goal individually and as a profession. We must appraise each problem before us on the basis of whether we, personally, or one of our available colleagues can render him the best service, and if consultation or reference to another for care is indicated we must consider the patient's welfare paramount. We will generally know whether a patient is able to pay a regular fee, a reduced fee, or none at all and so be guided, not, how-

ever, at any sacrifice of the quality of service rendered.

It will avail the public little good to carefully set up in each community a 24-hour provision for emergency service if we as individuals fail to cooperate in its execution. Those of us practicing as specialists in limited fields cannot leave the responsibility of emergency or night work entirely to the general practitioner. In our larger communities the Orthopedist, the Obstetrician, and the Psychiatrist must be willing to respond to the emergency occasioned by a broken arm, an unexpected hemorrhage, or a fit—the Surgeon, to an acute pain in the belly and the Internist, to an attack of the hives, occasioned perhaps by medication prescribed or given by himself. Let us accept the inconveniences incident to our own specialty and share cheerfully the burden of the "Neighborhood Doctor" or the general practitioner.

Our allied professions are affected by the same problems that beset us. The Dentist, the Nurse, the Pharmacist, the Veterinarian and the Minister are all our steadfast friends—our affairs intimately concern them and theirs concern us. Let us draw closer together individually and as organizations to better provide improved health to all our people. United let us stand—divided, we may yet, in the long run, fall.

*Sam A. Overstreet*

PRESIDENT

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# County Society Reports

## BELL

A called meeting of the Bell County Medical Society was held at the Middlesboro Hospital on Thursday, November 9, 1950, at 7:30 P. M.

Members present were: Drs. Ed Wilson, Jr., Waller Griffing, C. B. Stacy, C. S. Scott, Winfred Smith, Arch Carr, Ralph Alford, J. C. Ausmus, S. H. Flowers, George Bolls, and C. L. Woodbridge.

Guests were: Drs. John Winebrenner, Burt Wiley, and Miss Fultz, of Knoxville, Tenn., Mr. Jack Monroe, Harlan, Dr. Gene Lynch, Middlesboro, Miss Alice Smith, Superintendent of Red Bird Hospital, and Mr. Bill Young, Pineville.

The minutes of the last meeting were read and approved. No new or unfinished business or committee reports were presented before the society.

The program was conducted by Dr. Burt Wiley, head of the Physical Medicine Department of the Acuff Clinic in Knoxville. He presented three patients and their case histories stressing the procedures being undertaken to rehabilitate these men and return them to their work. Much discussion followed each presentation and all members showed much interest and enthusiasm. Meeting adjourned.

Charles S. Scott, Secretary.

## BRACKEN-PENDLETON

The regular monthly meeting of the Bracken-Pendleton County Medical Societies was held at the Phoenix Hotel, Falmouth, October 22, 1950. Members present: Drs. C. F. Haley, J. M. Stevenson, J. M. Blades, W. M. Townsend, B. N. Comer, H. A. Lewis and guests, Drs. Lawrence Hiltz and S. B. Gibson, Covington. Dr. J. M. Stevenson gave a report of the recent meeting of the State Medical Association. The scientific program consisted of an interesting paper given by Dr. Lawrence Hiltz, Covington, on "The Toxemia of Pregnancy." Following a short business meeting a buffet supper was served at the hotel. There being no further business the meeting adjourned.

C. F. Haley, Secretary.

## GARRARD

At the annual meeting of the Garrard County Medical Society, November 28, dues were received from the following: Drs. V. G. Kin-

naird, Paul Sides, F. G. Estridge, W. Samuel A. Harris and J. E. Edwards. The following officers were elected: Drs. J. E. Edwards, President, Paul Sides, Secretary, V. G. Kinnaird, Delegate to State Meeting.

Dr. B. B. Montgomery being absent from the meeting, Dr. W. Samuel A. Harris was selected to serve on County Board of Health.

There being no further business, the meeting adjourned.

J. E. Edwards, Secretary.

## JEFFERSON

The 943rd meeting of the Jefferson County Medical Society was held Monday evening, October 16, 1950, at the Seelbach Hotel. Eighty-eight members and guests were present for dinner and about twenty additional for the scientific program.

The meeting was called to order at 7:50 p. m. by Dr. Charles Bryant, 1st Vice-President who presided in the absence of the President.

Mr. F. Davis, Superintendent, American Printing Houses for the Blind, extended an invitation to members of the Society to attend open house October 26th to see all departments in operation.

Dr. Morris Flexner introduced the guest speaker, Erich Uhlmann, M. D., Chief of the Tumor Clinic, Michael Reese Hospital, Chicago, Illinois, whose subject was "Atomic Energy and Medical Science." This address was sponsored by the Jewish Hospital.

The business meeting began at 8:55 p. m. and the minutes of the last meeting were read and approved.

Dr. R. O. Joplin, Chairman, Building Committee, read a letter from the Co-operative Realty Corporation presenting a plan whereby the Society could buy space for a permanent meeting place in the old Baptist Orphanage at First and St. Catherine which is being remodeled. Members having questions should refer them to the Building Committee.

Resolutions on the deaths of Dr. Herman A. Mercer and Dr. Llewellyn F. Spears were read.

The following new members were elected to active membership: Drs. I. R. Berger, William A. Blodgett, Thomas R. Havens, Robert L. McClendon, Roxie T. Mudget. Associate Membership: Frederick C. Ehrman and George C. Stege.

The meeting adjourned at 9:15 p. m.

Robert Lich, Jr., Secretary.



**MADISON**

The regular monthly meeting of the Madison County Medical Society was held at Berea College Hospital at 7:30 P. M., October 12, 1950, Dr. H. H. Rutledge, President, presiding.

**Business Meeting:** The appointment of the present members to the County Board of Health by the State Board of Health for two years, approved by the Society by motion made in usual manner, passed by those present.

Dr. Hugh Mahaffey explained suicide case to the Society, Dr. John Armstrong pointed out that it was the hospital's responsibility to notify the proper authorities.

Dr. Earl Hays was presented to the Society as a new member.

Dr. D. M. Munnell as program chairman for the month presented the guest speaker of the evening, Dr. Willard Buttermore of Harlan, whose subject was "The Management of Traumatic-Nonperforating Corneal Injuries, Resulting from Industrial Accidents, particular to Coal Mining.

Dr. Buttermore pointed out that non-perforating wounds most frequent were foreign bodies, lacerations, abrasions, piercing, actinic and chemical.

The type of injury determines the kind of treatment. Most of his cases were compensation cases. It is always necessary that vision be checked, eyegrounds be carefully examined, dye used to determine injury to cornea, anesthesia of eye necessary to remove foreign body and use slit lamp.

Treatment consists of bland ointment for abrasions and compound empirin for pain, lacerations from coal, rock and metal exploded in face and eyes, cleanse, antibiotics locally, streptomycin instill every two hours, hot compresses of plain water, usually heal in four to six days, opacities depend on depth of lacerations.

Coal is chemically an inert substance. In very painful injuries pontocaine ointment is used and tight bandage applied to fix eyeball. Foile makes a good burn ointment. Doctor Buttermore warned against the use of penicillin drops in eye because of local reactions to this type of therapy. Riboflavin reduces scar formation. Vascularizations Beta radiation is effective and one to three treatments necessary for good results. Ulcers are treated by pasteurization, whole blood or blood plasma. Vitamin C is good. Cortisone is also effective. For allergy of eye antihist is used.

This was followed by a discussion by all present and was another excellent program.

Following this Dr. Hugh Mahaffey was introduced by Dr. Robert Sory as the new Coun-

cilor for the newly formed eleventh district.

The meeting adjourned at 9:05 P. M.

Max E. Blue, Secretary.

**McCRACKEN**

The regular meeting of the McCracken County Medical Society was held at the Ritz Hotel with Dr. Charles Billington presiding. There were 20 members and 7 guests present.

The scientific program consisted of an interesting paper on "Cancer of the Lung," by Dr. Thomas Burford, Associate Professor of Surgery, Washington University School of Medicine, St. Louis, Missouri.

The minutes of the previous meeting were read and approved.

Dr. Eugene Sloan reported on the professional insurance policies. Motion was made by Dr. J. A. Ward, seconded by Dr. C. J. Purdy, and passed unanimously to file his report.

The application of Dr. J. M. Hunt, Kevil, was read. Motion was made by Dr. Eugene Blake, seconded by Dr. H. G. Sargent, and passed unanimously to refer his application to the board of censors to report at the next meeting.

Motion was made by Dr. Errett Pace, seconded by Dr. George H. Widener, and passed unanimously to pay Paducah Press \$3.00.

Motion was made by Dr. H. G. Sargent, seconded by Dr. C. J. Purdy, and passed unanimously to pay Dr. Errett Pace \$8.50 for hotel bill and dinners for Dr. Lyle Motley and his associate.

Motion was made by Dr. Leon Higdon, seconded by Dr. Eugene Blake, and passed unanimously to accept Lloyd G. Yopp as a student member.

Motion was made by Dr. H. G. Sargent, seconded by Dr. C. J. Purdy, and passed unanimously that Dr. L. M. Weaver serve on the Association of Commerce Board to represent the McCracken County Medical Society.

Motion was made by Dr. Eugene Sloan, seconded by Dr. E. W. Jackson, and passed unanimously that Dr. Charles Billington serve on the Citizens Health Committee.

Motion was made by Dr. H. G. Sargent, seconded by Dr. Wm. Eaton, and passed unanimously that the next meeting be on December 20th, for the purpose of electing new officers for the next year.

A committee was appointed by Dr. Charles Billington to investigate the Pittsburg Plan and to report at the next meeting.

Dr. Leon Higdon reported that a total of \$1129.00 had been spent on the Advertising Campaign during the month of October and that more money is to be spent. He also report-

ed a good response to the Blue Cross-Blue Shield Plan. He emphasized the importance of better public relations.

Dr. H. G. Sargent requested that he be sent a bill for his dues so he may remain a member in good standing.

Meeting adjourned at 10:00 P. M.

Errett Pace, Secretary.

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### MUHLENBERG

The Muhlenberg County Medical Society met October 21, 1950 with the following members present: Drs. Claude Wilson, F. M. Wilson, G. L. Simpson, G. L. Richardson, J. L. Webster, R. E. Davis, B. B. Holt, G. F. Brockman.

The meeting was called to order by the Vice President, Dr. Foster M. Wilson and minutes of the preceding meeting were read and approved.

Dr. G. L. Simpson, for the Public Relations Committee, submitted a motion that the Society sponsor an advertising campaign in the newspaper in conjunction with, but supplemental to, the advertisement being presented through the A.M.A. offices. Motion carried.

Dr. J. L. Webster presented discussions on Rheumatic Fever and Peptic Ulcer. A broad discussion followed.

On motion the meeting adjourned.

G. F. Brockman, Secretary.

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### MUHLENBERG

The Muhlenberg County Medical Society met November 3, 1950 and members present were: Drs. H. H. Woodson, G. H. Rodman, George Richardson, R. E. Davis, J. P. Walton, B. B. Holt, A. W. Andreasen, G. F. Brockman.

The meeting was called to order by the President, Dr. H. H. Woodson. Minutes of the preceding meeting were read and approved.

President H. H. Woodson reported a request from the Auxiliary for guidance in projects for the ensuing year.

In the ensuing discussion, great admiration was expressed for the very satisfactory manner in which the Auxiliary had conducted their nurse recruitment program of last year.

It was moved that two projects be suggested for the Auxiliary: a. That they provide active assistance to the Board of Trustees of the Muhlenberg Community Hospital in the Boards plans for expansion of the hospital. b. That they provide the laboratory of the Muhlenberg Community Hospital with a modern type of microscope.

Dr. George Richardson, Beechmont, presented an excellent paper on "Jaundice in Infancy," discussing the differential diagnosis and management of the cases. This was illustrated with a report of a case of Choledochus cyst.

On motion the meeting was adjourned.

G. F. Brockman, Secretary.

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### SCOTT

The Scott County Medical Society met at the local Hospital on November 2, 1950 with the following members present:

Drs. H. G. Wells, L. F. Heath, W. S. Allphin, D. E. Clark, F. W. Wilt, A. F. Smith, E. C. Barlow and H. V. Johnson.

Minutes of the previous meeting were read and approved.

Dr. D. E. Clark announced that the plans were on hand to organize a professional men's club composed of Doctors, Lawyers and Ministers.

The Society unanimously endorsed the appointment of Drs. W. S. Allpine, F. W. Wilt and E. C. Barlow to the Scott County Board of Health.

The Secretary read a statement endorsing the Bond Issue for the addition to the Hospital and it was unanimously carried.

There being no further business the meeting adjourned.

H. V. Johnson, Secretary.

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### SCOTT

The monthly meeting of the Scott County Medical Society was held at the John Graves Ford Memorial Hospital on Thursday, December 7, 1950, with the following members present:

Drs. H. G. Wells, L. F. Heath, W. S. Allphine, F. W. Wilt, D. E. Clark, Jr., E. C. Barlow, A. F. Smith and H. V. Johnson.

Minutes of the previous meeting were read and approved.

Mrs. Morris, our Hospital Superintendent, read a letter from the American College of Surgeons urging us to comply with their requests and we can be recognized.

Motion was made and seconded that a staff be organized and records kept properly so that the Hospital can be recognized. Carried.

Election of officers of the Society for 1951 was held with the following results:

President, Dr. W. S. Allphin  
Vice-President, Dr. D. E. Clark  
Secretary, Dr. H. V. Johnson  
Censor 3 yrs., Dr. H. G. Wells

Censor 2 yrs., Dr. A. F. Smith  
Censor 1 yr., Dr. W. S. Allphin  
Delegate, Dr. H. V. Johnson  
Alternate, Dr. E. C. Barlow.

Dr. W. S. Allphin appointed Drs. H. G. Weils and A. F. Smith to act as our representatives on the Board of Trustees of the Hospital.

On motion and seconded it was unanimously voted that Dr. J. W. Baird be elected a Member Emeritus of the Society and be released from dues. Carried.

Motion made and seconded that County dues be raised to two dollars a year. Carried.

There being no further business the meeting adjourned.

H. V. Johnson, Secretary.

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### SHELBY-OLDHAM

Dr. S. B. May, Eminence, entertained the Shelby-Oldham Society and the Ladies Auxiliary with a turkey dinner at the Stone Inn on November 16th.

The following members and guests were present: Dr. and Mrs. H. B. Mack, Dr. and Mrs. S. B. May, Dr. and Mrs. L. B. Sternberg, Dr. and Mrs. B. F. Shields, Dr. and Mrs. M. D. Klein, Dr. and Mrs. L. A. Wahle, Dr. and Mrs. Allen, Dr. and Mrs. McMunn, Dr. and Mrs. E. G. Houchin, Dr. and Mrs. G. B. Perrine and Drs. W. H. Nash, B. B. Sleadd, A. D. Doak, H. H. Richeson, J. T. Walsh, A. C. Weakley, C. C. Risk, Mrs. L. L. McBride and Mr. William Coffman.

Following the dinner the ladies retired to another room for the auxiliary meeting.

President Mack called the meeting to order. Minutes of the last meeting were read and approved.

Drs. M. L. Klein, A. D. Doak and L. W. Sternberg were nominated for members of the

Shelby County Board of Health.

Drs. A. C. Weakley, S. B. May and J. T. Walsh were appointed as a committee to arrange for the Essay contest for the children of Shelby County that is sponsored by the Association of American Physicians and Surgeons.

Election of officers will be made at the December meeting. Drs. A. C. Weakley, E. G. Houchin and W. B. McKee were named the nominating committee.

At this time the meeting was turned over to Dr. S. B. May, the host, and he introduced Mr. William Coffman of the State Board of Health. Mr. Coffman plans to examine all the school children of the County for deafness and he outlined the method of this examination. The Society went on record as in favor of this work.

Meeting adjourned at 9:30 P. M. The next meeting will be December 21st at 7:00 P. M. at the Stone Inn.

C. C. Risk, Secretary.

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### WARREN-EDMONSON-BUTLER

The Warren-Edmonson-Butler County Medical Society met in Bowling Green at Helm Hotel on 14 November for its monthly dinner and scientific program. Dr. Martin Wilson has received orders to report for duty with the Navy in December. The Society voted to give a small gift and to have a party to honor Dr. Wilson.

Dr. William Meacham, Professor of Neuro-Surgery at Vanderbilt Medical School, gave a most interesting discussion with illustrations of Cerebral Aneurysms.

Dr. Sam E. Paris, Ophthalmologist, Bowling Green, talked on Ocular Muscle Imbalance.

The meeting adjourned.

Frank H. Moore, Secretary.

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## News Items

Dr. Ben C. Stigall has opened an office in Livermore, McLean County, for the general practice of medicine. He was graduated from the University of Louisville School of Medicine in 1948 and served a one year internship with the U. S. Navy. Dr. Stigall came to Livermore from Oklahoma City where he had been employed by the Veterans Administration at the Oklahoma City Veterans Hospital.

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A virus research laboratory which will concentrate upon childhood infections has been established at the University of Louisville

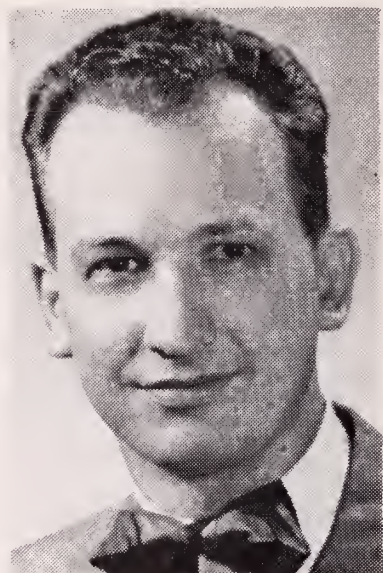
School of Medicine. Its completion was effected by a grant from the recently organized Kentucky Child Health Foundation. The investigations will be supervised by Drs. Alex J. Steigman and James G. Shaffer of the school's Child Health and Bacteriology Departments.

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Charles C. Rutledge, M. D., opened his office in Pikeville, January 1, 1951, and will limit his practice to general surgery. Dr. Rutledge was born in 1917, in Richmond, and was graduated from the University of Louisville School of Medicine, in 1942. After spending three years



in the Armed Forces, two of which were in the European theatre of operation, Dr. Rutledge returned to Nichols Hospital, Louisville, where he completed his qualification for the American Board of Surgery. His father, John H. Rutledge, M. D., and his brother, Harold H. Rutledge, M. D., both practice at Richmond, the latter being the president of the Madison County Medical Society.



**REINHOLD ENGLEMAN, M. D.**

**Glasgow**

Dr. Engleman was graduated from the Washington University School of Medicine, St. Louis, in 1943 and had internship rotating in character at the St. Louis City Hospital. Following this he was resident physician in tuberculosis for two residencies at Robert Koch Hospital, St. Louis, which is the tuberculosis service of St. Louis City Hospital. Later he went on active duty in the Army Medical Corps assigned to Fitzsimmons General Hospital, Denver, remaining there 3 years on the tuberculosis branch of the medical service. Upon his discharge, Dr. Engleman became staff physician at Battey State Hospital, Rome, Georgia, where he remained until his assignment at Glasgow as Medical Director and Superintendent, State Tuberculosis Sanatorium, District Six.

Dr. Lawrence Emberton, a native of Tompkinsville, has opened an office for the practice of medicine in Edmonton. He was graduated from the Medical College of the State of South Carolina, Charleston, in 1948 and served his internship in Fordham Hospital, at which hospital he also served a one year residency in Internal Medicine.



**W. B. ATKINSON, M. D.**

**Lebanon**

Dr. Atkinson has served in the following capacities in our organization:

President of the Taylor County Medical Society.

Secretary of the Taylor County Medical Society.

President of Muldraugh Hill Medical Society for 2 years.

Member of the House of Delegates for 24 years.

Delegate to the A. M. A. to fill unexpired term of the late Virgil E. Simpson, Louisville.

Councilor of the 6th District for 12 years.

Vice-President 1949-1950.



**W. LANDON SMITH, M. D.**

Dr. W. Landon Smith, a native of Frankfort, is now associated with Dr. Walter Lee O'Nan at Henderson in the practice of general medicine. Dr. Smith is a graduate of the University of Louisville School of Medicine in 1949. During World War II Dr. Smith served as pharmacist mate in the Navy Medical Corps for four years.

Dr. V. A. Jackson, Clinton, has just completed a twelve room air conditioned clinic including a modern X-ray equipment, a certified clinical laboratory, emergency operating room, four rooms for examination and treatment of out-patients, and one bedroom for overnight patients and a dental suite. Dr. Jackson was graduated from the University of Louisville School of Medicine in 1941 and is a veteran of World War II.

Dr. C. C. Howard, Glasgow, who has been chairman of the state research commission since it was created in 1948, was re-elected to that position at a meeting of the commission November 16, 1950.

## *In Memoriam*



**JOHN DARLEN ALLEN, M. D.**

**Louisville**

**1882 - 1950**

Dr. John Darlen Allen, a physician in Louisville for thirty-eight years, died October 15, 1950 of a heart attack. Dr. Allen was a native of Hale County Alabama. He was graduated from the University of Louisville Department of Medicine in 1912, and had been associated with the Louisville Research Laboratory since graduation. He was pathologist at St. Anthony's Hospital and consulting pathologist at Kentucky Baptist Hospital and is a member of the American Board of Pathologists, and College of Pathologists. Dr. Allen was a past president of the Jefferson County Medical Society.



**RUBY HELEN PAINE, M. D.**

**Berea**

Ruby Helen Paine, M. D., Berea College Hospital physician was killed instantly in an automobile accident near Marshall, North Carolina.

Her death brought an end to a life of service which began with a year in county practice after completion of her medical degree at the University of Illinois in 1912. For ten years she was a missionary at Sierra Leone in "Darkest Africa," where she was surgeon, obstetrician, pediatrician, and general practitioner, covering a territory of 1800 square miles. In 1927 she was appointed on the faculty of Berea College. Dr. Paine was a past president of the Madison County Medical Society, a Fellow of the American Medical Association, and a member of the Southern Medical and the Kentucky State Medical Associations.

**L. D. MASON**

**Middletown**

**1876 - 1950**

Dr. L. D. Mason, Middletown, died October 11th, 1950. Dr. Mason had practiced medicine in Louisville for forty-eight years. He was educated at Washington & Lee University and the University of Louisville Medical Department from which he was graduated in 1902.

During World War I he was commissioned captain in the Army Medical Corps and was on the examining board at Camp Taylor. During World War II he was on the Selective Service Board that included Middletown. In 1935 he was a staff physician at the Kentucky Children's Home, Lyndon.

Interested in boys work, he formed a Boy Scout troupe at Middletown and was a Scoutmaster for many years.





**FRANK M. GAINES, M. D.**

Carrollton

1870 - 1950

Dr. Frank M. Gaines, Carrollton, died October 5, 1950. He was born in Ghent on January 30, 1870. He was graduated from the University of Louisville Medical Department in 1893 and immediately began the practice of his profession with his father in Carrollton. During World War I he served in the Army Medical Corps, and was stationed at Hines Hospital, Chicago, and at Outwood, Dawson Springs. From 1921 to 1939 he served with the Public Health Service and the Veterans Administration.

**HERMAN A. MERCER, M. D.**

Louisville

1896 - 1950

Dr. Herman A. Mercer, Jeffersonville specialist, died October 4, 1950 of a heart attack. A native of Pretty Prairie, Kansas, Dr. Mercer came to Louisville in 1945 as an eye, ear, nose and throat specialist, and opened his offices in Jeffersonville two years ago. He was graduated from the Medical Department of the University of Oklahoma in 1922. He was a member of the Jefferson County Society and the Kentucky State Medical Association.

**THORNTON WEATHERS PERKINS, M. D.**

Hopkinsville

1875 - 1950

Dr. Thornton Weathers Perkins died of coronary thrombosis March 15, 1950 in Hopkinsville.

Dr. Perkins was born on June 5, 1875 in Elkton. Completing high school in Elkton he went to the Virginia Military Institute, and thence to the College of Physicians and Surgeons of Baltimore where he was graduated in 1900. The following year he interned in the Baltimore City Hospital.

A Captain in the army, he spent two years in military service during the Spanish American War, most of this time in the Philippines.

Dr. Perkins practiced in Owensboro for a year and in Elkton until 1909 when he moved to Hopkinsville where he practiced internal medicine until just a few weeks before his death.

**A. M. ROWE, M. D.**

1862 - 1950

Bowling Green

Dr. A. M. Rowe, Bowling Green, died unexpectedly in his sleep October 2, 1950. Dr. Rowe was born in Hart County, October 2, 1862. He was a practicing physician in Glasgow for several years before moving to Bowling Green in 1908. He was graduated from Hospital College of Medicine in 1898, Louisville.



**CORINNE BUSHONG, M. D.**

Tompkinsville

1912 - 1950

Dr. Corinne Bushong, Tompkinsville, died October 16, 1950. She was born in Tompkinsville November 27, 1912. She attended Western State Teachers College, Bowling Green, from which she received her A. B. degree in 1933. She was graduated from the University of Louisville School of Medicine in 1940 and served her internship at the Louisville General Hospital, since which she had been an active practitioner in Tompkinsville.

"We are told," wrote William Graham Sumner in 1889, "what fine things would happen if every one of us would go and do something for the welfare of somebody else; but why not contemplate also the universal gain which would ensue if everybody would do something for himself."—Connecticut State Medical Journal, March, 1950.



## BOOK REVIEWS

**PRINCIPLES OF GENERAL PSYCHOPATHOLOGY, An Interpretation of the Theoretical Foundations of Psychopathological Concepts,** by Siegfried Fischer, M. D., Clinical Instructor in Psychiatry, University of California; Formerly Professor of Psychiatry and Neurology, University of Breslau. Philosophical Library, New York, Publishers.

The first part of the book deals with fundamentals of psychopathological concepts. Each chapter starts with a psychological introduction for the understanding of the psychopathological symptoms, all of which are described and defined.

The second part of the book deals with the psychological connections. Here the author investigates what dynamic psychology and dynamic psychopathology really are and what their scientific foundations are. In this part of the book the author takes a critical attitude to psychoanalysis, although with deep respect for the psychoanalytical school. An important new concept is added for the understanding of neuroses.

In the third part the pathological syndromes or symptom-complexes are described and the diseases in which they are found are designated. The fourth part deals with the foundations of personality, character and temperament and their deviations in pathological cases. It deals, besides, with the relationship between personality and psychosis.

In the last chapter the author delineates the psychopathic from the neurotic personality.

As this subject is now a public fad as it were, the physician who reads this book can have knowledge enough to know where to land in this unknown sea of the thought world.

call for a book devoted to these subjects. In the effort to meet this demand the authors have endeavored to present the current concepts on the subject. Matters of science and technic that have stood the test of time have been retained, and an earnest effort has been made to supply informative details on important newer developments. Utmost care has been taken to keep the work within the limits of a practical textbook and guide to technic. The reader in search of comprehensive discussion of controversial matters will find access to the literature in the articles and books listed in the Bibliography.

There is no need to comment on the authority of the material. The Drs. Jackson are known throughout the world as pioneers in and masters of this field.

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**PHYSICIANS' AND NURSES' CONCISE MEDICAL ENCYCLOPEDIA** by William H. Kuppér, M. D., author of *Malarial Therapy of Paresis; State and National Board Summary; Interesting and Useful Medical Statistics*. Biblion Press, Publishers, 257 South Spring Street, Los Angeles, California.

This concise medical encyclopedia is an attempt to bridge the gap between medical dictionaries which say too little about too much; and the medical tomes which say too much about too little too often in the microscopic type which can be read only with difficulty.

For the benefit of many of our readers the synonyms supplied in this book are Spanish, not typographical errors.

The many illustrations are from the U. S. Army Medical Museum, White Memorial Hospital, Los Angeles.

The general practitioner will welcome this book because it is a convenient size for the office desk.

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**BRONCHOSOPHAGOGY:** By Chevalier Jackson, M. D., Sc.D., LL.D., F.A.C.S., Honorary Professor of Bronchoesophagology and Laryngeal Surgery, Temple University, Philadelphia; and Chevalier L. Jackson, M. D., M.Sc., F.A.C.S., Professor of Bronchoesophagology and Laryngeal Surgery, Temple University, Philadelphia. 366 pages with 260 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price \$12.50.

Complete exhaustion of three editions of a textbook on bronchoscopy and esophagoscopy and its translation into French (Crucoin), Italian (Peroni), Spanish (Molina), and Japanese (Ono) indicate not only world-wide interests in endoscopic examination and treatment of the air and food passages, but also an urgent

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**PATHOLOGIC PHYSIOLOGY: Mechanisms of Disease:** Edited by William A. Sodeman, M. D., F. A. C. P. The Wm. Henderson Professor of the Prevention of Tropical and Semi-Tropical Diseases, Tulane University of Louisiana School of Medicine; Senior Visiting Physician, Charity Hospital of Louisiana; Consultant in Medicine, U. S. Marine Hospital at New Orleans. 808 pages with 146 figures and 30 tables. Philadelphia and London: W. B. Saunders Company, 1950. Price \$11.50.

This volume, a collaborative effort by 25 authors, approaches problems of disease in the field of Internal Medicine from the standpoint of disturbed physiology. Unlike the usual text, which is devoted to discussions of etiology, pathology, symptoms and treatment, this work

analyzes symptoms and signs and the mechanisms of their development. The monograph is not intended to take the place of standard textbooks of medicine. It does not aim at the completeness of either, but does try to bridge the gap between them by presenting a clinical picture of disease seen as physiologic dysfunction. An attempt is made to promote understanding of how and why symptoms appear, so that the student or physician may have a reasonable explanation for the findings he elicits. Neurologic problems are considered only as they are related to the various disease groups. The same is true of metabolic disturbance and disorders of acid-base balance. It is highly valuable as a reference book.

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**THE PROSTATE GLAND**, by Herbert R. Kenyon, M. D., Associate Clinical Professor, Department of Urology, New York University, Bellevue Medical Center. Random House, Publishers, New York. Price \$2.95.

Men in middle life and in old age are confronted with the actuality or the prospect of suffering from any one of the many disabilities and diseases of the prostate gland. In order to give authoritative information and guidance to laymen, Dr. Herbert R. Kenyon, eminent urologist, here clarifies in simple, non-technical language the importance of the male gland which plays so vital a role in sexual activity and reproduction. He explains the diseases it is heir to and the medical and surgical means by which it can be restored to its normal function, rendered harmless, or removed entirely. The medical and surgical procedures are explained, and diagnosis, treatment and prognosis are given with such candor and simplicity that any one who reads can understand.

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**QUINIDINE in Disorders of the Heart** by Harry Gold, M. D., professor of Clinical Pharmacology at Cornell University Medical College, Attending-in-Charge of the Cardiovascular Research Unit at the Beth Israel Hospital, Attending Cardiologist at the Hospital for Joint Diseases, Managing Editor of the Cornell Conference on Therapy. Paul B. Hoeber, Inc., Medical Book Department of Harper and Brothers, Publishers, New York City. Price: \$2.00.

This concise manual shows how to obtain maximum therapeutic results from the use of quinidine in disorders of cardiac rhythm. This book takes up each disorder for which quinidine is effective, explains the physiologic mechanism involved, shows the precise therapeutic objective, explains the particular action of

quinidine on which reliance is being placed, points out any dangers which may rise, gives the doses and course of treatment in precise detail, and discusses the toxic effects of quinidine and their control. Particular stress is placed on the rationale of every procedure recommended in the book.

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**WHEN MINDS GO WRONG, A SIMPLE STORY OF THE MENTALLY ILL, PAST, PRESENT AND FUTURE**, by John Maurice Grimes, M. D., twenty years a psychiatrist, four years a staff member of the Council on Medical Education and Hospitals of the American Medical Association, and author of *Institutional Care of Mental Patients in the United States*. First Edition, 237 pages, illustrated. Published and distributed by the author, 5203 South Harper Avenue, Chicago, 15. Price \$5.00.

This is a very valuable book for psychologists, sociologists and social workers and to all associations who are interested in alleviating the misfortune of mental illness. It contains many interesting case reports which include the writer's technique in restoring persons to normal lives. The writer has had unlimited experience as he directed a two year investigation of mental hospitals for the American Medical Association. The price of the book has been reduced to \$5.00 so it can be more widely distributed.

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**SIR WILLIAM OSLER APHORISMS** From his bedside teachings and writings, collected by Robert Bennett Bean, M. D., Edited by William Bennett Bean, M. D., Henry Schuman, Inc., Publishers, 20 East 70th St., New York 21, N. Y., Publishers. Price \$2.50.

The late Sir William Osler was probably one of the best loved and certainly one of the most influential physicians in modern medicine. He was always concerned not only with the specifics of medical research and progress, but with the much broader, humanistic aspects of medical science. And he was exceptionally cosmopolitan and sophisticated, often wryly humorous, in his outlook.

His "Boswell," the late Robert Bennett Bean, jotted down many of Sir Williams' reflections and observations and also culled a large number of aphorisms from Sir William's writings. These have now all been collected in this volume by Dr. William Bennett Bean, Robert Bean's son. The result is a distillation of Sir William's philosophy and a volume of inspiration and counsel for all interested in medical practice.



1950

# CONSTITUTION AND BY-LAWS OF THE KENTUCKY STATE MEDICAL ASSOCIATION

## CONSTITUTION

- Article I. Name of the Association
- Article II. Purpose of the Association
- Article III. Component Societies
- Article IV. Composition of the Association
- Article V. House of Delegates
- Article VI. Sections and District Societies
- Article VII. Sessions and Meetings
- Article VIII. Officers
- Article IX. Funds and Expenses
- Article X. Referendum
- Article XI. The Seal
- Article XII. Amendments

## BY-LAWS

- Chapter I. Membership
- Chapter II. Annual and Special Sessions of the Association
- Chapter III. General Meeting
- Chapter IV. House of Delegates
- Chapter V. Election of Officers
- Chapter VI. Duties of Officers
- Chapter VII. The Council
- Chapter VIII. Committees
- Chapter IX. Assessments and Expenditures
- Chapter X. Rules of Conduct
- Chapter XI. Rules of Order
- Chapter XII. County Societies
- Chapter XIII. Amendments

## CONSTITUTION

### Article I. Name of the Association

The name and title of this organization shall be the Kentucky State Medical Association.

### Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge, and to the advancement of medical science, to the elevation of the standard of medical education and to the enactment and enforcement of just medical laws; to the promotion of friendly intercourse among physicians and to the guarding and fostering of their material interest and to the enlightenment and direction of public opinion in regard to the great problem of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

### Article III. Component Societies

Component societies shall consist of those county medical societies which hold charters from this Association.

### Article IV. Composition of the Association

The Association shall consist of the members of the component societies as defined in the By-Laws.

### Article V. House of Delegates

**Section 1.** The House of Delegates shall be the legislative and business body of the association.

**Section 2.** Delegates shall be members of and elected by component societies in accordance with the By-Laws. Officers of the Association and Delegates to the American Medical Association and the five immediate Past-Presidents shall be ex-officio members of the House of Delegates and entitled to a vote.

**Section 3.** The Speaker or Vice-Speaker shall preside during the meetings of the House of Delegates. The Presiding Officer shall not be entitled to a vote except in the event of a tie vote.

**Section 4.** The House of Delegates shall be the final judge as to the qualification of its members.

### Article VI. Sections and District Societies

The House of Delegates may provide for a division of the scientific work of the Association into appropriate Sections and for the organization of such Councilor District Societies as will promote the best interest of the profession, such societies to be composed exclusively of members of component county societies.

### Article VII. Sessions and Meetings

The Association shall hold an annual session and such special sessions as may be desirable in accordance with the By-Laws of the Association.

### Article VIII. Officers

**Section 1.** The Officers of this Association shall be a President, a President-Elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, and a Councilor from each Councilor District that may be established and such other Officers as provided for in the By-Laws.

**Section 2.** The Officers of the Association shall serve for the term of office and subject to provisions as specified in the By-Laws.

**Section 3.** All Officers shall serve until their successors have been elected and installed.



**Section 4.** The Officers of the Association shall be elected at the last session of the House of Delegates at the annual session of the Association and shall take office on that day unless otherwise specified.

#### **Article IX. Funds and Expenses**

Funds for meeting the expenses of the Association shall be arranged for by the House of Delegates by an equal per capita assessment upon each county society to be fixed by the House of Delegates by voluntary contribution and from the profits of its publication. Funds may be appropriated by the House of Delegates to defray the expenses of the Annual Session, for publication and for such other purposes as will promote the welfare of the Association and profession.

#### **Article X. Referendum**

The General Meeting of the Association may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may, by a similar vote of its own members or after a like vote of the General Meeting, submit any such question to the membership of the Association for a final vote; and if the persons voting shall comprise a majority of all the members, a majority of such vote shall determine the question and be binding upon the House of Delegates.

#### **Article XI. The Seal**

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

#### **Article XII. Amendments**

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at that Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

### **BY-LAWS**

#### **Chapter I. Membership**

**Section 1.** A member of this Association must be a member of one of the component societies and when certified to the Secretary of the Association as a member of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association the name of the member shall be included in the official roster of the Association and the member shall be entitled to all the privileges of his class of membership.

**Section 2.** Active White Members. Active white members shall comprise the active members of the component medical societies. To be eligible for active membership in any component county society the applicant must be:

A. A doctor of medicine who is licensed to practice medicine in the State of Kentucky and who is of good moral and professional standing.

B. A medical officer of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

C. Any doctor of medicine engaged in scientific or professional pursuits whose principles and ethics are consonant with those of the State Association.

**Section 3.** Associate Members. Associate members shall consist of associate members of the component medical societies who are not eligible for active membership and who are qualified under one or more of the following groups:

A. An intern, resident or teaching fellow who is a Doctor of Medicine but who is not licensed to practice medicine in the state.

B. A person who is not a Doctor of Medicine but who is engaged in scientific, professional or other pursuits, whose principles and ethics are consonant with those of the Association.

C. A Doctor of Medicine residing and practicing outside the area covered by the component society and who is an active member in good standing in his own component society.

Associate members shall not have the right to vote nor to hold office. The Council shall, from time to time, determine the amount of dues to be charged. Associate members shall receive the Journal and the publications of the Association.

**Section 4.** Emeritus Members. Component societies may elect as a Member Emeritus any Doctor of Medicine who has retired from active practice and who has previously maintained active membership in good standing in his society. Emeritus members shall not have the right to vote nor to hold office and shall not pay dues. They shall receive the Journal and other publications of the Association.

**Section 5.** Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in an accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. The Council shall determine, from time to time, the amount of dues to be charged. Student members shall receive the Journal of the

Association. The membership year for student members shall run from September 1 to August 31 of each year.

**Section 6. Honorary Members.** Any physician possessed of scientific attainments who is a member of a constituent State Medical Association and who has participated in the program of the Scientific Session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privilege on the floor in all scientific sessions.

**Section 7. Guests of Honor.** Any distinguished physician not a resident of this State may become a guest of honor during any annual session upon invitation of the Association or its Council and shall be accorded the privilege of participating in all of the scientific work of that session.

**Section 8.** The name of a physician upon the properly certified roster of members or list of delegates, of a chartered county society which has paid its annual assessment, shall be prima facie evidence of his right to register at the Annual Session in the respective bodies of this Association.

**Section 9.** No persons who are under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from its rolls of membership shall be entitled to any of the rights or benefits of this Association, nor its proceedings until such time as he has been relieved of such liability.

**Section 10.** Each member in attendance at the Annual Session shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that session. No member or delegate shall take part in any of the proceedings of an annual session until he has complied with the provision of this section.

## **Chapter II. Annual and Special Sessions of The Association**

The Association shall hold an annual session and such special sessions at such time and place as may be determined by the House of Delegates.

The General Meeting shall include all registered active members, associate members and guests. Associate members and guests shall not have the right to vote on pending questions, but shall have equal rights with active members to participate in the proceedings and discussions. Each General Meeting shall be presided over by the President or in his absence or

disability or upon his request, by one of the Vice-Presidents. Before it, at such time and place as may have been arranged, shall be delivered the annual address of the President, and the annual orations and the entire time of the sessions as far as may be, shall be devoted to papers and discussions relating to scientific medicine.

## **Chapter IV. House of Delegates**

**Section 1.** The House of Delegates shall meet annually at the time and place of the Annual Session of the Association and shall so fix its hours of meeting as not to conflict with the first General Meeting of the Association, or with the meeting held for the address of the President and the annual orations so as to give delegates an opportunity to attend the other scientific proceedings and discussions so far as is consistent with their duties. But if the business interest of the association and profession require, it may meet in advance or remain in session after the final adjournment of the General Meeting. The House of Delegates may be called into special session by the President with the approval of the Council and a special session of the House of Delegates shall be called by the President on a written request of the delegates representing fifty or more component county societies. When such special session is called the Secretary shall mail a notice of the time and place and purpose of such meeting to the last known address of each member of the House of Delegates at least ten days before such special session.

**Section 2.** In the event there is no duly authorized delegate in attendance at the regular meeting of the House of Delegates the President shall consult any duly elected officer of the component society who is in attendance and with the approval of the Credentials Committee may appoint any active member of the component society in attendance at the meeting as the delegate. In the event there is no duly elected officer of the component society in attendance, the President may make the said appointment with the approval of the Credentials Committee. All appointments made shall also be with the approval of the House of Delegates.

**Section 3.** A majority of the registered delegates shall constitute a quorum and all of the meetings of the House of Delegates shall be open to members of the Association. The House of Delegates shall have the right to go into executive session whenever such action is indicated in the judgment of the House of Delegates, except that active members of the Association shall have the right to attend all executive sessions.

**Section 4.** From among the members of the House of Delegates the Speaker of the House of Delegates shall appoint a Nominating Com-



mittee, a Committee on Credentials, Rules and Order of Business, Report of Officers and the Council, Report of Standing Committees, Report of Special Committees, Report of Advisory Committees, Resolutions, Miscellaneous Business, Revision of By-Laws and Constitution, and such other committees as he may deem necessary, as well as Tellers and Sergeant-At-Arms. All appointments by the Speaker of the House of Delegates are subject to approval by the House of Delegates.

**Section 5.** Each Resolution introduced into the House of Delegates shall be in writing and presented to the Secretary. Immediately after the Delegate has introduced the Resolution it shall be referred to the proper Reference Committee before action thereon is taken.

**Section 6.** No new business shall be introduced in the last meeting of the House of Delegates without unanimous consent of the Delegates except when presented by the Council. All new business so presented shall require three-fourths affirmative vote for adoption.

**Section 7.** It shall, through its officers, Advisory Council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Session a stepping stone to further ones of higher interest.

**Section 8.** It shall consider and advise as to material interest of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

**Section 9.** It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who can be made reputable, has been brought under medical society influence.

**Section 10.** It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

**Section 11.** It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

**Section 12.** It shall upon application provide and issue charters to county societies organized to conform to the spirit of the Constitution and By-Laws.

**Section 13.** In sparsely settled sections two or more County Societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The County Society thus combined shall not lose any of its privileges and representation. The active members of each County Society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the State Association.

**Section 14.** It may divide the counties of the State into Councilor Districts, and, when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, to meet midway between the annual sessions of the Association, and members of the chartered county societies and none other shall be members.

**Section 15.** It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

**Section 16.** It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

**Section 17.** The complete proceedings of the House of Delegates shall be published in the Journal of the Association.

#### Chapter V. Election of Officers

**Section 1.** The President-Elect and the Vice Presidents shall be elected for a term of one year. The Speaker and Vice-Speaker of the House of Delegates shall be elected for a term of three years. The Secretary and Treasurer shall be elected for a term of five years. The Councilors shall be elected for a term of three years and shall be limited to serving for not more than two consecutive terms. The terms shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice-President, Speaker or Vice-Speaker of the House of Delegates or Councilor who has not been an active member of the Association for at least five years.

**Section 2.** All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect, provided, however, that when there are more than two nominees the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting continue until an election occurs in like manner.

**Section 3.** Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of this Association shall be ineligible for any office for two years.

**Section 4.** The election of officers shall be the order of business in the House of Delegates on the last day of the General Session.



**Section 5.** The nominating committee shall nominate candidates for all offices except that of Councilors and shall make its report to the House of Delegates. Additional nominations may then be made from the floor by any member of the House of Delegates.

**Section 6.** The Delegates from the counties in each Councilor District shall form the Nominating Committee for the purpose of nominating a Councilor for the Councilor District concerned. This committee shall hold a meeting open to all active members of Councilor District concerned who are in attendance at the meeting for the purpose of discussing the nomination for the Councilor to serve the District. Additional nominations may be made from the floor by any member of the House of Delegates when the nominating committee makes its report to the House of Delegates.

#### Chapter VI. Duties of Officers

**Section 1.** The President shall preside at all general meetings of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such other duties as customary and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Councilors in building up the county societies and in making their work more practical and useful.

**Section 2.** The President-Elect shall be chairman of the Committee on Scientific Assembly, and shall appoint one active member of the Association to serve on this Committee. He shall become President of the Association at the next annual meeting of the Scientific Session following his election as President-Elect. He shall assist the President in visitation of county and other meetings and shall be ex-officio a member of the House of Delegates with the right to vote. In event of death, resignation, or if he becomes permanently disqualified, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at the next annual meeting of the Scientific Session of the Association.

**Section 3.** The Vice-Presidents shall assist the President in the discharge of his duties. In the event of his death, resignation or removal, the Council shall elect one of the Vice-Presidents to succeed him.

**Section 4.** The Speaker of the House of Delegates of the Association shall preside at all meetings of the House of Delegates. He shall appoint all committees for the House of Delegates with the approval of the House of Delegates. He shall be an ex-officio member of all said committees. He shall perform such other

duties as custom and parliamentary usage may require.

**Section 5.** The Vice-Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, resignation or removal of the Speaker, the Vice-Speaker shall automatically become Speaker of the House of Delegates.

**Section 6.** The Treasurer shall give bond for the trust imposed in him whenever the House of Delegates shall deem it requisite. He shall demand and receive all funds due the Association, together with the bequests and donations. He shall, under the direction of the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall in general subject to such direction have the care and management of the fiscal affairs of the Association. He shall pay money out of the Treasury only on written order of the President, countersigned by the Secretary; he shall subject his accounts to such examinations as the House of Delegates may order, and he shall annually render an account of his doings and of the state of funds in his hand.

**Section 7.** The Secretary, acting with the Committee on Scientific Assembly, shall prepare and issue the program for and attend all meetings of the Association and of the House of Delegates and he shall keep minutes of their respective proceedings in separate record books. He shall charge upon his books the assessments against each component county society at the end of the fiscal year; he shall collect and make proper credits for the same and perform such other duties as may be assigned him. He shall be custodian of all record books and papers belonging to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association which may come into his hands. He shall provide for the registration of the members and delegates at the Annual Session. He shall keep a card index register of all practitioners of the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association for publication. In so far as it is in his power he shall use the printed matter, correspondence and influence of his office to aid the Councilors in the organization and improvement of the county societies and in extension of the power and usefulness of this Association. He shall conduct the official correspondence, notify members of meetings, officers of their election, and committees of their appointments and duties. He shall act as secretary of the Committee on Scientific Assembly. He shall be editor of the Kentucky Medical Journal. He

shall employ such assistants as may be ordered by the Council or the House of Delegates. He shall annually make a report of his doings to the House of Delegates.

In order that the Secretary may be enabled to give that amount of his time to his duties which will permit of his becoming proficient it is desirable that he shall receive some compensation. The amount of his salary shall be fixed by the House of Delegates.

#### **Chapter VII. The Council**

**Section 1.** The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws. The Council shall consist of the duly elected Councilors. The President, the President-Elect, the Speaker of the House of Delegates, the Secretary and the Treasurer shall be ex-officio members of the Council with the right to vote. The Executive Committee of the Council shall consist of the President, the Chairman of the Council, and the Secretary. The Executive Committee shall exercise the powers of the Council between sessions of the Council and be directly responsible to the Council for all their actions.

**Section 2.** The Council shall hold daily meetings during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three councilors. It shall meet on the last day of the Annual Session of the Association for reorganization and for the outlining of the work for the ensuing year. At this meeting it shall elect a chairman and secretary and it shall keep a permanent record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the account of the Secretary and Treasurer and other agents of this Association and shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. In the event of a vacancy in any office the Council may fill the same until the annual election.

**Section 3.** Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his doings, and of the condition of the profession of each county in his district to each Annual Session of the House of Delegates. The necessary traveling expenses incurred by Councilor in the line of his duties

herein imposed may be allowed by the House of Delegates upon a proper itemized statement, but this shall not be construed to include his expense in attending the Annual Session of the Association.

**Section 4.** Collectively the Council shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies or to this Association. All questions of an ethical nature brought before the House of Delegates of the General Meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or a county society upon which appeal is taken from the decision of an individual Councilor. Its decision in all such cases shall be final.

**Section 5.** The Council shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation and other important matters to the public and the lay press. Such communications shall be officially signed by the Chairman and Secretary of the Council as such.

**Section 6.** The Council shall provide for and superintend the publication and distribution of all proceedings, transactions and memoirs of the Association and shall have authority to appoint such assistants to the editors as it deems necessary. It shall manage and conduct the Kentucky Medical Journal, which is the organ of the Association, and all money received by the Journal, the Council or any officer of the Association, shall be paid to the Treasurer of the Association on the first of each month.

**Section 7.** All reports on scientific subjects and all scientific discussions and papers read before the Association shall be referred to the Kentucky Medical Journal for publication. The editor, with the consent of the Councilor for the District in which he resides, may curtail or abstract papers or discussions, and the Council may return any paper to its author which it may not consider suitable for publication.

**Section 8.** All commercial exhibits during the Annual Session shall be within the control and direction of the Council.

#### **Chapter VIII. Committees**

**Section 1.** The Standing Committees shall be as follows:

- A Committee on Arrangements
- A Committee on Scientific Assembly
- A Committee on Public Relations
- A Committee on Medical Economics
- A Medico-Legal Committee

and such other committees as may be necessary. Such committee shall be appointed by the President of the Association in conference with the Secretary unless otherwise specified. The President and Secretary shall be ex-officio





a. Ulcerative amebiasis during Diodoquin therapy. In this patient with severe hemorrhage, edema and necrosis, the ulcers show healing, with many scars. No active lesions are seen.



Photographs courtesy of Louis H. Block, M. D., Chicago

b. Three months later, after continuing Diodoquin therapy, extensive scarring indicates healing. Inflammation is further reduced and only superficial areas of inflammation remain.

**AMEBIASIS:** "Diodoquin is probably the least toxic of the drugs and contains the most iodine."<sup>1</sup> "Diodoquin now appears to us to be the drug of choice [for outpatients] because of its effectiveness and because it is tolerated well by most patients."<sup>2</sup>

In acute or latent forms of amebiasis, Diodoquin® (diiodohydroxyquinoline) the potent amebacide, may be administered in large dosage over prolonged periods. Diodoquin contains 63.9 per cent of iodine... is tasteless... relatively nontoxic... orally administered.



1. Johnson, S. K.: Mississippi Doctor 27:69 (July) 1949.

2. Merritt, W.: J. Florida M. A. 35:351 (Dec.) 1948.



members of all committees except as otherwise specified.

**Section 2.** The Committee on Arrangements shall consist of as many members and sub-committees as are deemed advisable. No county medical society, as such, shall serve as the host society. The Chairman shall report an outline of the arrangements to the Secretary for publication in the program and shall make such announcements from time to time as may be desired. All expenses of the Committee on Arrangements shall be paid out of the funds of the Association that are made available for that purpose.

**Section 3.** The Committee on Scientific Assembly shall consist of at least five members of which the President-Elect shall be a member and Chairman. The Secretary of the Association shall be a member and Secretary of the Committee. The President-Elect shall appoint one member who shall serve a three year term. The Committee shall determine the character and scope of the scientific proceedings of the Association, subject to the provisions or the instructions of the House of Delegates or of the Association or to the provisions of the Constitution and By-Laws. Thirty days previous to each annual session it shall prepare and issue a program announcing the order in which papers, discussions and other business shall be presented which shall be adhered to by the Association as nearly as practicable.

**Section 4.** The Committee on Public Relations shall consist of at least five members. The President shall be a member and Chairman. The Secretary of the Association shall be a member and Secretary of the Committee. The President shall appoint one member who shall serve a three year term. Under the direction of the House of Delegates it shall represent the Association in securing and enforcing legislation in the interest of the public health and scientific medicine. It shall keep in touch with the profession and public opinions, shall endeavor to shape legislation so as to secure the best results for the whole people and shall utilize every organized influence in local, state and national affairs and elections. Its work shall be done with dignity becoming a great profession and with that wisdom which make effective its work and influence. It shall have authority to be heard before the entire Association upon questions of great concern at such times as may be arranged during the annual session.

**Section 5.** The Medical Economics Committee shall consist of a Chairman and such members as may be appointed by the President. It shall be concerned with and responsible for all matters of Medical Education and Medical Economics which shall be within the province of the State Medical Association. It shall con-

tinually strive to serve as a liaison between the public and the Medical Association in these matters.

**Section 6.** The Medico-Legal Committee shall consist of three members, one of whom, the Chairman, shall be elected by the Council for five years, and the Secretary and Treasurer shall be the other two members ex-officio. This Committee shall select and fix the compensation for an attorney, who shall act as general counsel, and if required, additional local counsel. The Association through this Committee shall defend its members who are in good standing against unjust suits for malpractice.

#### **Chapter IX. Assessments and Expenditures**

**Section 1.** The assessment of fifteen dollars per capita on the membership of the component societies is hereby made the annual dues of this Association. The Secretary of each county society shall forward its assessment together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association on the first day of January in each year.

**Section 2.** Any county society which fails to pay its assessments, or make the report required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

**Section 3.** All motions or resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose indicated and must be approved by the Council and House of Delegates.

#### **Chapter X. Rules of Conduct**

The principles set forth in the Principles of Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

#### **Chapter XI. Rules of Order**

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

#### **Chapter XII. County Societies**

**Section 1.** All county societies now in affiliation with the State Association or those that may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall upon application to the House of Delegates, receive a charter from and become a component part of this Association.

**Section 2.** As rapidly as can be done after the adoption of this Constitution and By-Laws,



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a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

**Section 3.** Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary of this Association. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

**Section 4.** Only one component medical society shall be chartered in any county. When more than one county society exists friendly overtures and concessions shall be made with the aid of the Councilor of the District if necessary and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

**Section 5.** Each county society shall judge of the qualifications of its own members, but as such societies are the only portals to this Association every reputable and legally registered physician who is practicing, or who will agree to practice nonsectarian medicine shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

**Section 6.** Any physician who may feel aggrieved by the action of the society of the county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, which upon a majority vote may permit him to become a member of an adjacent county society.

**Section 7.** In hearing appeals, the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a Board and as individual councilors in district and county work, effort at conciliation and compromise shall precede all such hearings.

**Section 8.** When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves.

**Section 9.** A physician living in or near a county line may hold membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

**Section 10.** Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every

physician in the county, and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

**Section 11.** Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do post-graduate and original research work, and to give the society the first benefit of such labors. Official position and other preferences shall be unstintingly given to such members.

**Section 12.** At the time of the annual election of officers each county society shall elect a delegate or delegates to represent it in the House of Delegates of this Association in the proportion of one delegate to each twenty-five members or major fraction thereof, and the secretary of the society shall send a list of such delegates to the Secretary of this Association at least 60 days before the Annual Session.

**Section 13.** The Secretary of each county society shall keep a roster of its members and a list of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information, upon blanks supplied him for the purpose, to the Secretary of this Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the Secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

**Section 14.** The secretary of each county society shall report to the Kentucky Medical Journal full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

**Section 15.** County societies may invite Dentists, Pharmacists, Funeral Directors, or other professional persons to become Associate Members of the County Society but such Associate Member shall not have any privileges or representations in the State Association.

### Chapter XIII. Amendments

These By-Laws may be amended by any Annual Session by a two-thirds vote of all the delegates present at that session, after the amendment has been laid on the table for one day.



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USES AND ABUSES OF THE CLINICAL LABORATORY

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LEXINGTON

*"Pyrrhic victory. A victory or success gained at too great a cost:—so-called in allusion to the exclamation of Pyrrhus, king of Epirus, after his defeat of the Romans at Asculum in Apulia (279 B. C.), in gaining which he lost a large part of his army:*

*'One more such victory over the Romans, and we are utterly undone' "* . . .

Webster's New International Dictionary.

The intelligent use of the clinical laboratory involves the understanding by both the laboratory and the attending physician of the problem presented and the nature and degree of precision of the answer.

The array of laboratory studies performed on the 15,000-odd in- and out-patients admitted to a 276-bed general hospital in 1948 reflects the dexterity of the technicians and the zeal of the attending physicians. In view of the cost to the patient, it behooves the considerate physician to choose wisely the laboratory procedures he orders, lest the successful diagnosis of his disease represent to the patient a Pyrrhic victory.

Dr. Roy Turner, in an editorial in the June, 1950, American Journal of Medicine (8), condemned the trend of physicians to visualize laboratory examinations solely in terms of a written report from a central laboratory which they rarely visit. Neglecting simpler examinations, they increase the demand for multiple and elaborate procedures beyond the budget of the laboratory, with resulting decline in the quality and reliability of the tests done.

Read before the Annual Meeting of the Kentucky State Medical Association, Louisville, September 28, 1950.

Table I  
Annual Report, 1948, Laboratory of a 276-Bed General Hospital

Department	Varieties of Tests	Number of Times Performed
Urine		
Routine	1	10,439
Other	19	54
Hematology		
Counts	5	39,671
Special	9	781
Hemostatic	3	1,181
Serology		
Syphilis	2	3,815
Grouping	3	11,869
Other	8	423
Spinal Fluid	13	2,309
Blood Chemistry		
Calcium	1	41
Other	32	3,730
Stool		
Chemical	4	100
Microscopic	4	206
Sputum	3	347
Transudates	3	21
Miscellaneous	9	1,880
Total	119	76,867

This leads, on the part of the attending physician, to a refusal to accept a result, good or bad, which fails to confirm his preconceived diagnosis. On the part of the laboratory, it leads to cynicism regarding the intelligence of the physician who requested the needless procedures.

The Physician's Responsibility

The physician's duty is, when possible, to restore his patient to active and productive life. Physical recovery may be delayed or negated by economic crippling.

or by anxiety engendered by high cost of diagnostic procedures. In justice to his patients, the physician should first make use of the relatively simple and inexpensive "screening tests." He should use the more exact (and therefore more expensive) procedures only when they are demanded by the clinical situation. When the use of such tests is necessary, it is the physician's duty not only to order them, but equally to insist that they be performed by a properly qualified laboratorian, and that the results be thoughtfully integrated with the patient's history, signs, symptoms, and previous laboratory work.

### Limitations

Ham (4) alludes to the eloquence of certain qualitative data in diagnosis, such as the presence of free hydrochloric acid in vomitus as excluding pernicious anemia; prolonged bleeding from a capillary puncture as indicating abnormal hemostasis; a wide buffy coat in a hematocrit tube as presumptive of leukemia; a low urinary specific gravity from a dehydrated person as presumptive of renal failure; or the inferences from the passage of a stone in the urine. However, the limitations of such results must be recognized: the passage of a stone does not differentiate alkalosis from parathyroid disease or cystinuria.

Certain semi-quantitative data, such as the several gradations of glycosuria, 1, 2, 3, and 4 plus, give more refined information. Ham, pointing out variations in erythrocyte counts on the same blood by different technicians, relegates this procedure to the semi-quantitative group. He points out the fallacy of trying to make a silk purse out of a sow's ear, of trying to derive an accurate figure for the mean corpuscular volume by using an accurate hematocrit reading and a red blood cell count with a large mirror.

Properly performed chemical analysis should yield data of precision within definite limits of reproducibility. The limits of reproducibility of a chemically sound method may be wide, however. It is of utmost importance that the attending physician recognize this fact, and be acquainted with the possible sources of error, before he spends his patient's money or commits his diagnosis on a laboratory figure.

### Commonest Sources of Errors

The commonest sources of error are (1) those inherent in the method; (2) errors

of sampling or preservation; and (3) technical errors in the performance of the test. Errors inherent in the method are usually worked out before the method is published, so that the limits of accuracy are defined. However it should be noted that the laboratory which develops a particular method of analysis will be interested in developing maximal accuracy, and often will have used pipettes and other measuring vessels which have been individually calibrated. This accuracy is not usually obtained in vessels sold commercially for routine work. Some methods are more foolproof than others, and thus are more reliable. The determination of non-protein nitrogen by acid digestion is far more reliable in routine work than is the determination of blood urea nitrogen which depends on digestion by an easily poisoned enzyme. But as published, both methods are equally accurate.

The attending physician is often responsible for errors in sampling and preservation. He should see that the patient is in the proper state of hydration, nutrition or fasting, and the like. He should also see that the proper type of container and preservative is used, and that the sample gets to the laboratory directly.

### Misleading Reports

Belk and Sunderman (1) reported the results of analysis of standard solutions by 59 clinical laboratories in Pennsylvania. Their figures show that in various analyses from two to thirty-three per cent of the laboratories reported results so grossly erroneous as to be totally misleading. These gross errors were not due to errors in sampling, for Belk and Sunderman had an independent referee verify the values of the solutions after the results were in. Errors inherent in the method were allowed for. Hence these errors represent inexcusably poor technique on the part of the laboratory.

Recently a 22-year-old man with hematuria was found to have a serum calcium of 16 mgm. per 100 cc., phosphorus of 4 mgm. per 100 cc., and alkaline phosphatase of 5.6 King-Armstrong units. His bones showed no osteoporosis, but pyelography demonstrated a right renal calculus. Then his urinary calcium excretion on a low calcium diet was shown to be three plus by a Sulkowitch test. The calcium and phosphorus determinations were repeated twice by the same laboratory:



Results were:

	1st attempt	2nd attempt	3rd attempt
Ca	16.0	17.6	17.1
P	4.0	4.45	4.3

At exproation his parathyroids showed no adenoma.

If we were to analyze the thinking in this case, we could demonstrate several processes, some orderly and others out of order.

First there was a suspicion of hyperparathyroidism raised by the presence of hematuria and renal calculus.

Next a definite answer was sought in the bone plates and the calcium, phosphorus, and phosphatase levels in the blood.

In view of the controversial results, a screening test was done, which showed the tenability of the diagnosis..

Then the supposed definite answer was scrutinized, rechecked, and found to be reproducible by the laboratory.

Interpretation of the figures as suggesting strongly the possibility of parathyroid adenoma was the result of Bodanskys' (2) figures showing that in hyperparathyroidism the blood phosphorus is depressed in only about 45 per cent of the cases.

Action followed interpretation and was disappointing.

Lest we forget him, the patient then made an expenditure of a sum of money.

It is submitted that the screening Sulkowitch test, which was recommended by the laboratory, should have been made before seeking the definite results of the calcium, phosphorus, and phosphatase determinations. In fact, had the problem been presented to the laboratory, the Sulkowitch test would have been recommended first. It is further submitted that the scrutinizing process was faulty in that it failed to allow for the fact that the same laboratory could make the same mistake three times in a row. Some excellent short-order cooks just can not make pastry. Referring back to Table 1, we note that the laboratory ran 41 calcium determinations during the year 1948. Eight technicians rotate through the blood chemistry department in three-month tours, so that disregarding seasonal fluctuations, the technician who performed the test had run the determination perhaps 10 times in the previous two years. In fairness to the laboratory, it must be noted that its figures were not proven wrong. The attending surgeon, believing

in the accuracy of the figures, recommended mediastinal exploration, which the patient refused.

### Routine of Ordering Tests

The routine of thinking in ordering laboratory tests should include these processes in the logical order:

- (1) Suspicion,
- (2) Screening,
- (3) Definition,
- (4) Scrutiny,
- (5) Interpretation,
- (6) Action,
- (7) Consideration of expense.

Furthermore, these steps should be pre-viewed, perhaps best in the form of a few questions. Is a diagnosis suspected or is the test ordered just as bait-casting? Is there any simpler way the diagnosis can be confirmed? Is a result of this test in this laboratory to be relied on? Will knowing this answer make any difference in the treatment of the patient? Is this test ordered for the benefit of the patient or for the edification of the physician?

### Teleological Approach

White and Geschickter's (9) book, "Diagnosis in Daily Practice," was facetiously reviewed as a scheme for the key-punch-machine diagnosis of the approximately 200 diseases which cause 98 per cent of the illnesses in the United States on the basis of 16 symptoms, 23 physical signs, and 6 laboratory findings. These authors stress the teleological approach to diagnosis: the physician who correctly diagnoses and manages a relatively small number of "imperative" diseases and a larger number of common fatal or disabling diseases, while avoiding too much early preoccupation with a brilliant diagnosis of a rare or therapeutically baffling disease, accomplishes the most for his patients in man-days of health.

### Routine Technics

The discussion of the streamlined history (3) and of the thoroughness of the physical examination is not pertinent to this paper. The reasoning of White and Geschickter regarding the office laboratory routine is relevant. They recommend a screening routine of urinalysis, hemoglobin determination, sedimentation rate, serologic test for syphilis, examination of the stool grossly and for occult blood, and photo fluorographic examination of the chest. They point out that positive findings in these examinations are common to many diseases, and that



positive results of these tests may be present without recognizable associated physical findings, so that they may lead to the recognition of disease in presymptomatic stages.

Other recent papers (4, 5, 6, 7, 9) have suggested somewhat different office screening routines. (Table II).

Konzelmann (5) considered that there are major pathological technics, such as bacteriologic diagnosis, tissue diagnosis, some phases of chemical pathology and hematology, which belong in the domain of the pathologist. Other minor pathologic technics developed in the laboratory should be passed on to the general office practice. He recommends that if no laboratory is within 50 miles the physician should set up in his office some one trained to perform routine urinalysis, complete blood count, blood sugar, urea, non-protein nitrogen, hematocrit, bleeding time, clotting time, prothrombin time, total bilirubin, and urine urobilinogen determinations.

Not as routine, but certainly as a very familiar endeavor, should be the gross and/or microscopic examination of all

abnormal exudates, secretions, and parasites.

Beyond this the office laboratory may go as far as it can produce accurate results in confirming the diagnosis. The choice of procedures will be governed by such considerations as frequency of indication, simplicity, likelihood of economic advantage, specificity and reliability of results, safety for the patient, and feasibility of having the test performed elsewhere (9).

Precision of Results

The precision of the results of the office laboratory depends on the constant scrutiny of the physician. He must be his own critic. Several base lines should be checked frequently:

- 1. The blank determination, that is, the amount of analyzed substance in the reagents cooked together without blood or other biological fluid.
- 2. The minute details of the cookery.
- 3. The zero points of the instruments and the calibration of apparatus.
- 4. Solutions of known strength to standardize the method.
- 5. The normal control. This should al-

Table II  
Routine Laboratory Data Recommended

	White and Geschickter	Konzelmann	Mandel, Lehmann, Paris	Ham	Mass. Dept. Pub. Health "Health Pre- vention Clinic"
Urine	Routine	Routine		Routine	Sugar, Albumin
Hematology	Hemoglobin and Sed. Rate	CBC	Sed. Rate	Hemoglobin or Hematocrit WBC, Diff.	Hemoglobin
Serology	STS	STS		STS	STS
Stool	Inspection Occult Blood			Inspection Occult Blood	Inspection Occult Blood
X-Ray	Chest				Chest
Chemistry			Creatinine Glucose Icterus Hayem		Glucose
Accessory					Vision Audiometer Papanicolaou if indicated

ways be the physician; his interest will be directed immediately to any abnormal result.

### Multiphasic Screening Clinic

The Massachusetts Department of Public Health and the Massachusetts Medical Society recently reported (7) the results of six months of operation of a "Health Protection Clinic." To correct the waste of money (up to \$20,000 to detect one case of carcinoma) and the false sense of security from other diseases engendered in patients cleared by the Cancer Mobile, the Heart Mobile, or the Tuberculosis Mobile, these organizations established a multiphasic screening clinic. Using a modified Cornell Medical Index (3) history filled in by the patient, eight laboratory examinations, and a twenty-minute interview and physical examination, the clinic saw during its first six months of part-time operation 2600 patients for \$14 apiece. It referred to their family physicians:

136 cases of obesity, 88 of visual defects, 58 of organic heart disease, 56 of hypertension, 49 of hearing defects, 14 of diabetes, 11 of anemia, 2 of early tuberculosis, 2 of syphilis, 2 of subsequently proven cancer, and 27 of premalignant lesions.

### Summary

1. The laboratory and the physician should work together, each realizing the problem at hand and the significance of the answer which may be expected.

2. In the use of the laboratory the physician should suspect a diagnosis, screen for it as cheaply as possible, and confirm it as directly as possible. He should scrutinize the result for possible errors, and should interpret the result into action. All the while he should consider the cost to the patient in terms of the value of the information yielded.

3. The physician who himself routinely performs and interprets a few simple and reliable laboratory tests of wide application can be secure in his diagnosis in the majority of cases. He can also more intelligently plan the use of more elaborate methods when they are needed.

4. The formulation of such a routine has been discussed, and results of its application have been cited.

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### DISCUSSION

Malcolm L. Barnes, Louisville: Papers of the nature of Dr. Darnell's excellent and timely presentation bring us face to face with the fact that pathology as the youngest of the specialties is coming of age.

Not too long ago the hospital laboratory was relegated to those basement rooms that could not be used for the heating plant or were unsatisfactory for storage, and the pathologist's income was made commensurate with his surroundings and those of his helpers kept in line with those of assistant janitors.

Recent trends have somewhat altered this condition and the swing, as a result of demonstrated abilities, has been toward laboratory medicine. This has been, on many fronts, over-emphasized, and I am the first to criticize, for isolated example, an icterus index on an obviously jaundiced patient when this is not intended to form a baseline determination to estimate progress or serve some other useful purpose.

A hospital's physical plant may be modern, its clinicians the community's best, and its equipment excellent but if the grade of pathology is inferior, a satisfactory level of medical care will not be rendered. Transfusion reaction, due to improperly matched blood, may nullify the otherwise brilliant surgical result. Poor slides and improper interpretation of cervical biopsy material may rob a woman of her chance of cure of early cervical cancer. Overlooked red blood cells in urine may prolong the period before malignancy of bladder or kidney is suspected and lessen the patient's chance for cure. On the other hand, the competent laboratory is daily providing material for diagnosis of unsuspected conditions or justifying the clinician's suspicion of some condition.

The pathologists are cognizant of their shortcomings and great pressure is being exerted by the College of American Pathologists and the American Society of Clinical Pathologists to standardize and improve techniques. To aid this we must educate our hospital administrators and our clinicians to the possibilities and



limitations of the laboratory. They must realize that a competent technician can do justice to approximate three complete blood counts in an hour. Modern chemistry requires adequate space and expensive equipment as well as "know-how." Autopsies require a full day or more of a pathologist's time to complete and half a day of his tissue technician and at least that much of his secretarial help and cleaning help.

We should like to emphasize Dr. Darnell's first point of summary. The laboratory and clinician should work together. We like to be thought of as a consultant and can often, we feel, render valuable assistance in this line. Many pathologists, like myself, are pathologists by "second intention," having put in some years of training in the clinical fields. The clinician should give the laboratory in-

formation. He should know how to make his requests. Don't just ask for a routine culture when actually both aerobic and anaerobic cultures may be indicated. Don't ask for an isolated agglutination in a case of unexplained fever when a battery done simply may provide the answer. Don't limit the examination of a sputum to a search for tubercle bacilli in an unexplained pulmonary disease.

Consider always the cost to the patient—unjustified expense and charges are the big reason American medicine is now fighting for its life.

Realize that though they work with many inanimate objects and even deceased or extirpated tissues that the pathologist and his aides are human and that mistakes are possible but that they are constantly being worked against.

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## ACCURACY OF DIAGNOSIS OF JAUNDICE

Stanley T. Simmons, M. D.

LOUISVILLE

In 1847, Virchow demonstrated that some of the pigment crystals in old hemorrhagic areas were identical with bilirubin. This discovery suggested the possibility that bile pigment is in part, at least, of extrahepatic origin, and experimental work with bile pigment metabolism has been in progress constantly since that time.

### Definition

Jaundice is the term applied to clinical conditions in which the tissues, sclera, skin, and mucous membranes are stained yellow by bile pigment. It has been recognized for a long time that this occurs in a variety of conditions associated with certain diseased states of the liver, the biliary passages, and some types of anemia. It is a state of hyperbilirubinemia, and is a symptom and not a clinical entity.

### Bilirubin

Bilirubin is formed from hemoglobin liberated from the break down of the erythrocytes in the body. The change of hemoglobin into bilirubin is due to the phagocytic action of the cells of the reticulo-endothelial system scattered throughout the body, but located chiefly in the bone marrow, spleen, and to a lesser extent in Kupffer cells of the liver. The

bilirubin thus formed is carried in the blood to the liver where it is taken up by the polygonal cells of the liver and excreted into the bile capillaries. The polygonal or hepatic cells proper, play no part in the manufacture of bilirubin. It now passes through the bile ducts to reach the gastro-intestinal tract. Here it is acted upon by the bacterial flora of the bowel, which converts it to urobilinogen. Most of the urobilinogen is excreted in the feces, but some is reabsorbed and carried to the liver by the portal vein to be again taken up by the polygonal cells and excreted in the urine.

By use of the Van den Bergh test it has been found that the blood normally contains .2 to .4 units of bilirubin. If from any disturbances in the body it increases to 4 units, the tissues are stained yellow, and jaundice is visible.

Thus, we may summarize by saying that the metabolism and excretion of bilirubin occurs in three major steps:

1. Manufacture of bilirubin by the reticulo-endothelial system.
2. Excretion of the pigment by the hepatic cells into the bile passages.
3. Passage of the bilirubin into the intestinal tract for conversion to urobilinogen and final excretion from the body in the stool. Disturbance at any one of these steps may lead to jaundice.



Such disturbances may be listed as follows:

1. Excessive destruction of red blood cells, the increased hemolysis leading to production of bilirubin at a rate beyond the excretory capacity of the liver cells.

2. Injury to the liver cells by disease or toxic agents so that they become unable to excrete the amount of bilirubin normally formed by the reticulo-endothelial cells.

3. Disruption of the biliary passages by disease of the liver cells, or from increased pressure which follows biliary obstruction, so that bilirubin already excreted by the liver cells can re-enter the general circulation.

### Classification

A completely satisfactory classification of jaundice has never been proposed. For practical purposes the classification of McNee published in 1923, is the most useful and inclusive. He divided it into three large groups: 1. Obstructive, 2. Toxic, or infectious, 3. Hemolytic. Later a fourth group has been added which is called mixed forms of jaundice. This group was proposed for the reason, as we all know, that many cases of jaundice start out as one type but soon secondary changes occur and we have both obstructive and toxic factors and sometimes hemolytic factors, all present at the same time.

### Hemolytic Jaundice

Briefly hemolytic jaundice may be due to a variety of causes and comes up for consideration chiefly in differential diagnosis when definite evidence of extra-hepatic mechanical biliary obstruction or definite disease of the liver cannot be found to explain existing jaundice. The type of hemolytic jaundice that concerns us mainly is the congenital hemolytic form. Usually the diagnosis is not difficult and the treatment is surgical.

The typical symptoms are:

- (1) Onset early in life,
- (2) Chronic jaundice,
- (3) Positive fragility test,
- (4) Chronic anemia,
- (5) Splenomegaly,
- (6) Familial incidence.

### Management

The primary responsibility of the doctor in the management of a case of jaundice is to decide whether the patient should be treated surgically or medically. Jaundice is frequently a sign of pancreo-biliary disease. It is, therefore, very necessary that the nature and location of the lesion

causing the jaundice be recognized if proper treatment is to be instituted. Recent advances in the knowledge of liver physiology with better medical and dietary treatment of liver disease; advances in the preoperative and post operative care in biliary tract surgery; and progress in the surgical management of malignant disease of the pancreas; offer a challenge for more accurate diagnosis.

Excluding hemolytic jaundice which has already been considered, it seems practical and plausible to divide jaundice anatomically and clinically into intra-hepatic and extrahepatic types. Intra-hepatic jaundice, known also as parenchymal or hepato-cellular, includes infectious hepatitis, the cirrhosis, and dystrophies. The management of this group is usually medical. Extrahepatic jaundice, also known as obstructive type, includes such lesions as: Common duct stone, carcinoma of pancreas, or bile passages and stricture. The treatment of this group is usually surgical.

### Etiology

In establishing the cause of jaundice in a given case, the first step is a careful exhaustive history. This should be followed by a careful physical examination. The relative diagnostic worth of such factors as age, sex, duration of jaundice, pain, fever, chills, history of previous attacks, digestive symptoms, alcohol and other liver poisons, weight loss, history of transfusions in recent weeks, splenomegaly, palpable liver or gall bladder, presence of ascites, angiomas, and color of stools cannot be passed over lightly. This should be followed by routine laboratory tests, urinalysis, complete blood count, sedimentation rate, Kahn, either an icterus index, or a quantitative serum bilirubin determination. In many cases a scout X-ray film of the abdomen with spot film over the gall bladder area should be made. If the cause of the existing jaundice is not apparent by this time, a surgical or medical consultation, as the case may be, should be the next step. If there is still doubt as to the diagnosis, liver function tests are in order.

### Diagnosis

In recent years the literature has literally teemed with methods of diagnosis of jaundice. In the main these methods are largely laboratory procedures, and constitute an attempt at the clinical application of known physiology of the liver.

### Liver Function Tests

The number of functions of the liver, as you know, are many and varied. No single liver function test has been found that will tell definitely that specific hepatic disease, does or does not exist; and furthermore, no such test is likely to ever be found. There are numerous liver function tests, but each one only tells us something about a single phase of hepatic function. The value of liver function tests are limited also by the great regenerative ability of the liver cell. Also by the great reserve power of the liver. When properly used, liver function tests are of immense value in the differential diagnosis of jaundice, especially in distinguishing between obstructive jaundice and jaundice due to liver cell disease. This is especially true in the early course of the disease. After a lapse of three weeks time much of their value is lost. The doctor who expects to use liver function tests should decide which function of liver he wishes to evaluate and select the test accordingly. It is better to use three or four tests and correlate the results than to use a single one. It must be remembered that tests involving the ability of the liver to excrete certain substances such as dyes are useless in patients with jaundice. It is also well to bear in mind that most sensitive liver function tests are not always the best for a given purpose. I refer to the hippuric acid test which has a very high sensitivity but is useless in the differential diagnosis of jaundice. The same is true of the bromsulphalein test. The cephalin cholesterol flocculation test is of some value in differential diagnosis if its results are properly evaluated. In hepatitis the result will be a frank four plus reaction in the majority of cases, while in obstructive surgical types of jaundice it will be either negative or show a one or two plus reaction. The plasma proteins usually decrease in any case of jaundice. In hepatitis, however, they not only decrease but a reversal of the A/G ratio occurs. This is usually not found in obstructive types of jaundice. The prothrombin time decreases more in obstructive than hepatic jaundice. If the prothrombin time is taken after the injection of a large dose of Vitamin K, the test may serve well as a tool in the differential diagnosis of medical and surgical jaundice. If there is a prompt rise of the prothrombin time to 100%, it may be said the case lies in the realm of surgery. In intrahepatic types of jaundice there will be a much smaller

rise and it will not be maintained. Of course, the quantitative determination of urobilinogen values in the urine and stools may be of value in the solution of this diagnostic problem. In hepatitis the urinary urobilinogen may equal or even be above the quantity of urobilinogen in the stools. On the other hand the amount of urobilinogen in the stools is many times greater than quantity found in the urine in incomplete obstructive surgical jaundice. In cases of complete obstruction, however, there are only traces less than 1 mg. of urobilinogen in the urine and little below 5 mg. in the stool. Giansiracusa and Althausen summarized this subject as follows: "The most decisive factor in differentiation between obstructive and parenchymatous jaundice is the ability of the liver to metabolize galactose and to produce prothrombin following an injection of Vitamin K. If these functions of the liver are not impaired, or are impaired only slightly, the case is in the domain of the surgeon. If they are greatly impaired, it is almost always a medical problem."

It is obvious that in addition to the above specific tests for jaundice the patient should have the various routine tests which are performed on any patient who complains of gastro-intestinal symptoms. Thus, gastric analysis and stool examination for other substances besides bile may be helpful.

### Value of X-Ray

All jaundiced patients in which diagnosis is at all obscure should have an X-ray study of the gastro-intestinal tract. A preliminary scout film of the abdomen as previously<sup>1</sup> mentioned should already have been made to rule out the possible existence of radio-opaque shadows that might indicate calculous jaundice. The Graham-Cole test for visualization of the gall bladder is not suitable in cases with jaundice because it has no diagnostic value since due to the jaundice there is little absorption of the dye and non-visualization of the gall bladder may serve only to confuse the picture. An X-ray study of the stomach and colon is advisable. Such a study may show, first, whether there is a primary lesion in either the stomach or colon which by metastasizing to the periportal lymph glands may have led to obstructive jaundice. A barium meal study may also show occasionally an abnormality of the duodenum as seen at times in pancreatic tumors, or deformities in the second portion of the duodenum as occur



sometimes in cases of carcinoma of bile ducts.

### Liver Biopsy

Liver biopsy as diagnostic procedure in the study of liver disease has been quite popular in many hospitals in recent years. Over two thousand cases have been reported in the literature. In skilled hands it is apparently a relatively safe procedure and may come to be used as a standard diagnostic procedure in cases of problem jaundice. It should not be done on patients whose prothrombin time is abnormal. Also it has the disadvantage of giving the pathologist a most tiny specimen which is obtained blindly from a large organ.

### Limitations of Diagnostic Methods

The experience of a group of Louisville hospitals in the management of jaundice has been evaluated. The purpose was to attempt to define the limitations of diagnostic methods through a frank appraisal of accuracy of diagnosis. The finding should reflect the experience of other hospitals throughout the country in the management of this medical problem.

The records of 150 cases hospitalized with the presenting symptom of jaundice have been reviewed. These patients were admitted on the general medical, surgical, and pediatric service of the hospitals. A large number of physicians and surgeons shared in their management. In each case the lesion was in the pancreo-biliary tract; the patients with hemolytic jaundice were excluded. In most instances the diagnosis was confirmed through surgical intervention, or post mortem examination. However, in the majority of cases of hepatitis and cirrhoses the diagnoses were necessarily clinical.

### Distribution of Cases

The distribution of cases was as follows:

- A. Intrahepatic jaundice—80.
  1. Hepatitis—56.
  2. Cirrhosis—24.
  3. Dystrophy—0.
- B. Extrahepatic jaundice—70.
  1. Calculus—42.
  2. Carcinoma of pancreas—16.
  3. Stricture common duct—2.
  4. Carcinoma of biliary tract—3.  
(Stones found in two cases)
  5. Hodgkins Disease—jaundice—ob-

struction common duct due to glands—1.

6. Malignancy of pancreas and common duct stones both—2.
7. Pancreatitis—1.
8. Chronic cholecystitis—1.
9. Undiagnoses—2.

There were two cases in which no diagnosis was made even after surgical exploration. They were probably cases of intrahepatic jaundice, though one may have been due to an anomaly.

An erroneous diagnosis between intrahepatic and extrahepatic jaundice was made in 6 of the 150 cases; an error of 4%.

In 10 cases a wrong diagnosis among the three types of extrahepatic jaundice (common duct stone, carcinoma, and stricture) was made, although the presence of extrahepatic jaundice was recognized. It is hardly fair to count these cases as erroneous diagnoses in as much as the causative lesion was placed outside the liver.

### Degree of Accuracy in Diagnosis

The degree of accuracy of diagnosis (96%) is surprisingly high. It is accounted for by the following factors:

1. A large number of cases of infectious hepatitis in young people and to several cases of homologous serum hepatitis.
2. Many cases of portal cirrhosis with typical history.
3. A large number of cases of common duct stone with typical history. The most frequent error was in diagnosing intrahepatic jaundice as stone in the common duct. This occurred in three cases in this series. In one case the pre-operative diagnosis was a pre-pyloric lesion of the stomach and the true diagnosis was gall stones. In two cases no definite cause for the existing jaundice was found even after exploratory laparotomy. In no case was a diagnosis of intrahepatic jaundice made on a case of extrahepatic jaundice such as common duct stone or carcinoma of the pancreas and laparotomy denied the patient.

### Treatment

Bookus states that the correct diagnosis of jaundice can be made at bedside in 80% of cases by purely clinical study. Lipp, et al, reporting on a series of 412 cases from the Buffalo General Hospital showed 90% accuracy of diagnosis. This writer also emphasized the importance of careful ap-



praisal of the clinical findings in the differential diagnosis of jaundice. He also called attention to the shortcomings of liver function tests in solution of the problem of jaundice. The experience of this hospital in the management of jaundice is in agreement with his conclusions. It has also been pointed out that a small group of patients, roughly about 10%, became baffling problems so far as diagnosis was concerned. These patients are usually 40 to 50 years of age, the history is not typical, physical findings are of no value, and laboratory tests are often misleading. Pain is frequently absent, and the jaundice either prolonged or recurrent. These patients are best handled by substituting intelligent management for a definite diagnosis. Such treatment consists of supportive symptomatic therapy for a six weeks period from the onset of jaundice and serial determinations of the icterus index or quantitative Van den Bergh tests at intervals of two weeks. If there has been no consistent decrease of the intensity of jaundice at the end of that time, exploratory laparotomy should be advised. Most cases of acute hepatitis will have cleared by this time. Those with acute or subacute yellow atrophy will have died. There will remain only the patients with obstructive jaundice which can either be cured by removal of a benign obstruction from the common duct or relieved by palliative anastomosis of the gall bladder to the duodenum or stomach if the obstruction is due to malignancy.

### Summary

1. 150 cases of jaundice in which the diagnosis was confirmed by operation, autopsy, or clinical course have been analyzed.

2. The relative value of data obtained from the clinical history, physical examination and laboratory study in the differentiation of intrahepatic and extrahepatic jaundice has been pointed out.

3. A program has been outlined for the effective management of that small group of cases in which no definite diagnosis as to type of jaundice can be made after the most exhaustive study.

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### DISCUSSION

**Thornton Scott, Lexington:** Dr. Simmons has presented to us in a most scholarly and comprehensive manner the difficult subject of jaundice. I am unable to differ with any statement he has made and shall therefore have to confine my comments to applause and emphasis. He has, in my opinion, assigned to their proper places and in correct proportion the many diagnostic methods in common use, placing greatest emphasis on a searching history not only of the individual but of his family. He has mentioned the importance of physical findings including inspection of the stools and urine. I think one can imply from his paper that the correct diagnosis may be made from the foregoing alone in a large majority of cases. With regard to inspection of the stool I should like to cite a pitfall into which I have occasionally fallen as a consultant, namely, the masking of clay colored stools by administration elsewhere of one of the numerous desiccated bile preparations. From the laboratory angle Dr. Simmons has quite properly stressed the importance of the early use of laboratory aids in order to avoid the confusion which arises from the fact that patients with longstanding obstructive jaundice exhibit cellular damage as well. It seems to me that the laboratory differentiation of jaundice should consist either of a very few fool-proof tests or the complete and complex barrage of flocculation, function and excretory tests. Random procedures are frequently inconclusive or entirely misleading. A few screening tests should be done immediately, including a reticulocyte count which would be elevated in case of increased blood destruction. Each clinician has his way of arriving at his own conclusions and a test which one may find useful may bewilder another. For example, a group of Boston workers has reported a phenomenally high incidence of correct diagnosis of cancer of the liver and biliary system from microscopic examination of the duodenal contents by the method of Papanicolaou, a procedure which would be useless in inexperienced hands.

In closing my discussion I should like to express my agreement with Dr. Simmons' conservative attitude towards needle biopsy of the liver. We have in many instances been helped by this method but to my mind the margin of safety is not quite wide enough and is not enough wider than exploratory laparotomy and the information obtained is not nearly as

complete. I say this in spite of the fact that I am an advocate of and have frequently made aspiration biopsies of other organs and masses and am also an advocate and practitioner of the method of Papanicolaou.

I am certain that no one can have heard Dr. Simmons paper without having a clearer idea of jaundice and how to approach its differential diagnosis with fewer and surer steps.

## PROSTATECTOMY TODAY

Robert Lich, Jr., M. D.

LOUISVILLE

The treatment of prostatism has been a source of debate and abuse since the turn of the century when Hugh Young introduced his method of perineal prostatectomy. At that time the controversy was limited to the suprapubic and perineal prostatectomies. This altercation was further embroiled by Davis when he introduced his electro-surgical unit that would cut under water and thus convert the cold punch transurethral route into a procedure of accurate hemostasis. The advent of a method which permitted prostatectomy without incision appealed to the medical profession and laity alike. It seemingly removed prostatectomy from the hazards of surgery and presumably only because of the lack of a visible wound. The transurethral resection enjoyed an immediate popularity throughout this country and in some areas it completely replaced open prostatectomy. This popularity seems to have receded in the past three or four years and the method of transurethral prostatectomy is gradually finding its proper place in the orbit of prostatectomy. Four years ago another method of prostatectomy found some favor. Mr. Terence Millin of London, England, introduced the "retropubic prostatectomy." We now have four tried methods of prostatectomy:

- (1) suprapubic prostatectomy
- (2) perineal prostatectomy
- (3) transurethral prostatectomy
- (4) retropubic prostatectomy

We have never held to any one method of prostatectomy and have always maintained that the method of prostatectomy should be geared to the specific patient and the prostatic adenoma to be removed. We have felt that the gland characteristics alone did not dictate the method, but

this coupled with the patient's individual findings indicated the method of choice. It follows then, that a urologist must attain proficiency in all methods and thus adapt the method to the patient and not require the patient to adapt himself to the surgeon's ability. Furthermore, it is our belief that in the present day era of laboratory dependence that the patient as an individual is often not evaluated and we thus assume the role of technicians rather than fulfilling our office as practitioners.

What then are the merits of the four methods of prostatectomy and what constitutes the indication for each?

### Suprapubic Prostatectomy

This method of prostatectomy, whether executed as a single or two stage procedure, has certain advantages which can not be denied by even those who execute the operation only occasionally. Its chief merit lies in its technical simplicity. It is a blind enucleating procedure that depends upon pressure for hemostasis and employs a postoperative cystotomy drainage which acts as a safe means of avoiding vesical overdistension if active postoperative bleeding should reappear. It is an operation that is relatively without hazard for the novice though it does not necessarily afford the patient the most economical and comfortable postoperative course.

Suprapubic prostatectomy has three great disadvantages and it is for these reasons that we employ the method but rarely. First, there is no consistent means of positive hemostasis and thus it does not afford the possibility of executing in every instance one of the basic dictums of surgery; namely, complete visualization of the operative field and positive control of bleeding. Second, this procedure requires that a structure (the bladder) be traversed which is effected only secondarily



ly and is not the seat of primary pathology. We do not feel that traversing the bladder affords the ideal approach to the prostatic adenoma any more than one would go through the stomach to approach the pancreas. Third, if per chance a prostatic neoplasm is encountered it does not lend itself to cope with this problem; of course, this latter criticism is not limited to the suprapubic method alone.

We employ the suprapubic method of prostatectomy under three conditions: (1) in an instance where a large vesical calculus (5 cm. or greater) is associated with prostatism; (2) when a diverticulectomy is anticipated in addition to a prostatectomy; and (3) in a situation where a cystotomy has been done previously to afford renal stabilization so that the bladder is already open and the suprapubic prostatectomy in this instance constitutes the logical surgical approach.

#### **Perineal Prostatectomy**

In perineal prostatectomy the most outstanding feature is adequate visualization of the entire surgical field so that positive hemostasis can be accomplished. This method of prostatectomy was our choice in dealing with the surgical removal of large or very large prostatic adenomata.

Perineal prostatectomy has never achieved popularity because of its route for surgical exposure which requires a comprehensive urological residency. The complications following perineal prostatectomy have been few in the hands of trained urological surgeons, but in the hands of the novice they have been numerous and devastating. Prolonged or permanent perineal urinary fistula and urinary incontinence are the two most common mishaps although rectal injury with the development of a recto-urethral fistula is often the only reward of the occasional perineal prostatectomist. We do not agree that the complications of perineal prostatectomy are any more numerous than in any of the other methods of prostatectomy; however, it is imperative that the operator have adequate training in this special surgical procedure and its postoperative management.

The perineal prostatectomy has much to recommend its use and high among these indications is the ease with which a radical prostatectomy may be done in the event that the enlarged prostate is found to be malignant at the time of operation. It is to be mentioned further that in instances

where the suspicion of malignancy is considered before operation it is possible by this means to expose the gland, biopsy the suspicious nodule or area and await the findings of the pathologist. If the diagnosis of prostatic cancer is confirmed a radical prostatectomy encompassing the prostatic capsule and seminal vesicles is done, whereas if no malignancy is found the conservative enucleating procedure is undertaken. This one great advantage of perineal prostatectomy must be given considerable consideration in evaluating this operation; no other method of prostatectomy has this to offer.

Among the disadvantages of the perineal method one must consider first the operative approach which is just anterior to the rectum and thus wound infection may occasionally present a problem. Healing in our experience even in the most resistant situations has never been as long as our most persistent suprapubic fistulae following a complicated suprapubic prostatectomy. Some patients develop painful perineal scars that are troublesome, but in our hands this complication has constituted less than 0.1 percent. The complication of temporary or permanent stress incontinence can occur though it is to be remembered that this can follow any type of prostatectomy. The outstanding and most common complication is sexual impotence and we never advise this method of prostatectomy if the patient states in his history that he is anxious to preserve his sexual functions.

The perineal method of prostatectomy has the advantages of affording a direct approach to the prostatic adenoma without traversing the bladder, positive hemostasis, low postoperative morbidity and mortality and cancer of the prostate can be dealt with adequately. Our present day indications for the perineal prostatectomy consist in (1) the inability to approach the gland anteriorly, (2) the possibility of neoplasm and the desire for a biopsy of a suspiciously hard area of the prostate.

#### **Transurethral Prostatectomy**

Undoubtedly this method of prostatectomy requires greater skill and judgment than any other urological procedure. This method can be time consuming for it literally whittles away the obstructing prostate. It seems both obvious and logical to us that to remove a small irregularity on a timber a chisel or plane would be the tool of choice, but if one were to remove

a projecting mass a saw or some other more radical and efficient method would be advisable. The same applies in prostatectomy, if the adenoma is small or moderately large it can be removed by transurethral resection to the benefit of the patient and operator alike; however, if it is a large gland and an hour is consumed in its piece meal removal then certainly an open operative procedure of twenty or thirty minutes would be far more acceptable. The inherent shock of transurethral prostatectomy is not greatly less than the perineal or retropubic method. As a group physicians and laymen alike consider the transurethral resection a benign procedure that is without hazard. Nothing could be more false for there is nothing more devastating than a transurethral resection that does not follow the usual pattern and presents a complicated postoperative course. Secondary hemorrhage, a complication of all methods of prostatectomy, can be profuse and uncontrollable which may necessitate open surgery for control and thus the benign procedure suddenly assumes proportions much greater than those offered by a well chosen open method of prostatectomy at the outset. Regrowth of the adenoma is another factor worthy of consideration.

What then are the indications for transurethral prostatectomy? It is the method of choice in (1) small or moderate adenomata, (2) vesical neck contractures, (3) hypertrophy of the bladder neck and (4) to offer the greatest possible chance in preserving sexual potency. The tissue can be removed by the skillful operator in a few minutes and the postoperative catheter may be removed the following day or within three days. The average patient leaves the hospital on the fourth or fifth day after operation. Occasionally because the patient does not want to run the risk of impotency we do a transurethral prostatectomy on an adenoma of great proportions. This is just an occasional patient and it is undertaken at the patient's request. Postoperative impotence is far less with the transurethral method than with any other method. We obtain information preoperatively concerning the desire of preserving potency and in these situations constitute the basis for my opening remarks concerning the fact that the operation must be geared to the adenoma and the patient who is unfortunate enough to harbor prostatic pathology. As an index of our use of the

transurethral procedure I might say that in 1949 this procedure was used in 67.3 percent of the patients in our practice that underwent prostatectomy.

### Retropubic Prostatectomy

The retropubic method of prostatectomy has the same advantages that are available by the perineal route. The prostatic adenoma is approached directly without traversing the bladder and accurate hemostasis is one of the attributes of this procedure as it is in the perineal method. It is true however that this method will not afford a biopsy of the posterior lobe. This disadvantage has become increasingly less undesirable as we have gained experience with this method of prostatectomy. More often than not it has been found that the diagnosis of cancer of the prostate has been possible by freeing the gland laterally and palpating the entire gland before going ahead with prostatectomy. If the gland feels firm and hard it has been shown to be cancer in all but one instance and in that particular patient the pathologist was hard pressed to decide definitely that the adenoma did not harbor some neoplastic change. The retropubic method of prostatectomy, in our hands, has largely replaced our previous enthusiasm for the perineal method. This is not difficult to understand for actually the retropubic prostatectomy is still the precise procedure of the perineal except that the gland is attacked from its anterior instead of its posterior aspect. The postoperative care is similar. We do believe however, and for this reason discontinued the perineal method, that the morbidity rate in the retropubic method is distinctly less than with the perineal method. The retropubic method of prostatectomy is certainly less complicated to learn and still it would seem from watching residents that a perineal apprenticeship would be an asset. We limit our use of the retropubic prostatectomy to large or very large prostatic adenomata or glands that are thought to harbor operable cancer (glands containing hard non-fixed nodules).

The details of the method of retropubic prostatectomy have been set forth in several journals and repetition beyond the fundamental details will not be undertaken at this time. The gland is approached through a transverse lower abdominal incision and the prostatic capsule is exposed and incised transversely. The ade-



noma is then demonstrated and enucleated with the finger and the prostatic urethra is severed by a scissors at the apex of the prostate. The adenoma is cut free at its vesical attachment. The prostatic arteries are sought and tied. After the prostatic bed is found free of bleeding a Foley catheter is introduced into the bladder per urethram and the prostatic capsule closed with a running suture. The abdominal wall is closed in layers and a small drain left in the Space of Retzius. It is unusual for the patient to experience anything other than a most benign postoperative course and the drain is removed on the third day while the urethral catheter is removed on or before the fifth day after surgery. If the patient complains too bitterly about the urethral catheter we have removed it as early as the second postoperative day without complication and little or no suprapubic urinary drainage which ceased spontaneously. This method of prostatectomy like any other surgical procedure, is not without potential complication and the surgeon must be prepared to deal with any and all extraneous happenings, but it has been our experience that the complications have been less frequent and our worst retropubic prostatectomy has not been nearly so bad as our worst perineal or suprapubic prostatectomy.

### Cancer of the Prostate

This is indeed another subject that would require as much time as we have devoted to the subject of prostatism. I believe however that there are some points that should be emphasized to complete this discussion. We employ the retropubic method of removing the carcinomatous gland in preference to the previously used perineal route. This is done for a definite reason since by the retropubic approach it is possible to visualize the entire procedure and particularly the removal of the seminal vesicles. In the perineal procedure the seminal vesicles must be dug out blindly. Our results have been gratifying, but the number of patients that have been acceptable for surgery have been small.

It is this point that I would like to bring to your attention. In our last 500 patients

seen for prostatic enlargement we have seen only 3 patients that were referred early enough so that they were fit subjects for radical prostatectomy while there were 86 patients that had inoperable cancer of the prostate. This is a tragedy. The patient seen early enough to permit the use of the radical prostatectomy (total prostatectomy with seminal vesiculectomy and partial vasectomy) has at least a 65 percent possibility of attaining a five year cure.

What then constitutes the sign of prostatic cancer and when is it operable? Early prostatic cancer manifests itself by the appearance of a hard nodule (single or multiple) and the prostate is moveable. Late or inoperable prostatic cancer demonstrates to the palpating finger in the rectum a stony hard prostate that is fixed to the neighboring structures and is not moveable. The prostate may or may not demonstrate distinct tenderness.

It is obvious then that the control of prostatic cancer is dependent upon rectal examination of the prostate in every patient that presents himself irrespective whether or not he has urinary complaints. Carcinoma of the prostate in its operable state is characteristically asymptomatic. Any dubious lesion of the prostate should be investigated and if necessary an open biopsy executed. I might mention further that a needle biopsy is valueless except to afford a histological confirmation of a grossly malignant prostate. The needle method for early prostatic cancer diagnosis is mentioned only to be condemned for its use has led many a physician into a trap and many a patient to his grave.

### Summary

The indications and contraindications of the four methods of prostatectomy have been discussed. A plea has again been registered for the early diagnosis of prostatic cancer because of the meager number of operable patients that find their way to the urologist.

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## CANCER OF ORAL CAVITY

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The term "cancer of the mouth" is a commonly used term to describe malignant tumors of the oral cavity. These tumors should not be classed together as "cancer of the mouth."

The various tumors arising in the oral cavity present distinct characteristics; they metastasize differently, the treatment varies, and the prognosis in each is different.

They account for about 4 or 5% of all malignant tumors, and about 70% of all cancer in the upper respiratory and alimentary tracts. Males are affected 5 times as frequently as females. Cancer of the lip and floor of the mouth occur 98% in males; cancer of the tongue, gums, tonsil, palate and cheek are 80 to 90% in males. It is primarily a disease of middle and old age, occasionally it occurs in the young and in infants.

### Etiology

The etiology is unknown, but several forms of chronic irritation are known to be contributing factors. The chronicity of the irritant is important. Prolonged overexposure to sunlight plays a part in cancer of the lower lip. Syphilitic glossitis is a frequent irritant. About 1/3 of all male patients with cancer of the tongue, have syphilis. Excessive smoking seems to play a part. Leukoplakia, tissue response to irritation, often precedes, or is associated with, cancer of the oral cavity.

The most frequent type is epidermoid carcinoma, about 90%. Adenocarcinoma is most often seen in the palate.

In order to expedite the discussion of the various oral cavity tumors, they will be divided into the following:

- (1) Carcinoma of the lower lip
- (2) Carcinoma of the upper lip
- (3) Carcinoma of the movable portions of the tongue (anterior 2/3)
- (4) Carcinoma of the floor of the mouth
- (5) Carcinoma of buccal mucosa
- (6) Carcinoma of upper gingiva
- (7) Carcinoma of lower gingiva
- (8) Tumor of hard palate
- (9) Tumor of lower jaw

### Carcinoma of Lower Lip

(1) Carcinomas of lower lip which arise on the cutaneous border, are basal cell carcinomas and belong in skin cancers. Carcinoma of lower lip is the most common of oral tumors—25%-30%. The majority develop half way between the midline and the buccal commissure. The lip becomes thickened and the induration may involve the entire half of the lip, while the ulceration is small and limited to the vermillion border. Or it may start as an ulcerating lesion, or at times it may be of the verrucous type. There is usually a history of a "blister" which usually precedes the ulceration. Or there may be a history of a recurring "scab" which leaves a bleeding ulceration. The lesions are slow growing, and produce no symptoms until advanced stages, and are frequently present for several years before advice is sought.

Metastases do not occur as frequently or as early as in other forms of oral carcinoma. The lymph drainage of lower lip is by one medial and two lateral trunks. The medial ends in the submental nodes, while the lateral trunks end in the submaxillary nodes. The submaxillary nodes are the most commonly invaded. When the submaxillary nodes become involved, about 12% show cervical node involvement. Metastases to the opposite side of the neck are rare. Submaxillary nodes rapidly become adherent to the skin.

Most can be diagnosed easily. However, a biopsy might be required and the specimen should be obtained with a scalpel, should be deep and include a part of the surrounding normal skin.

It is to be differentiated from herpes, long standing hemangiomas, chancre (rare on lower lip), hyperkeratosis and leukoplakia.

### Treatment

Roentgentherapy may be the treatment of choice but in certain conditions surgical excision may be preferable:

(1) With a small lesion and a large mouth it will give assurance of control and satisfactory esthetic results and is more expeditious.



(2) With extensive lesions roentgen-therapy may not give esthetic results.

(3) With small or large lesions which have already metastasized, thus allowing immediate care of the adenopathy.

(4) With previous inadequate X-ray treatment.

The treatment of metastatic adenopathy is by radical neck dissection, after the primary lesion is eradicated by surgery or controlled by roentgentherapy.

Prophylactic neck dissection should not be a routine procedure, unless

(1) The lesion is growing rapidly.

(2) The carcinoma is undifferentiated.

(3) The tumor has invaded the buccal commissure and the upper lip.

(4) When there has been a previously unsuccessful treatment of the primary site.

Prognosis for carcinoma of lower lip is excellent, being about 80% five year survival, when no metastases are present on initial examination, and about 25% five year survival when metastases to submaxillary nodes are present.

### **Carcinoma of Upper Lip**

These occur much less frequently than in the lower lip and a greater proportion occur in the female. They occur frequently near midline, may never ulcerate, and infiltrate the entire thickness of the lip. The majority are epidermoid carcinomas. They grow more rapidly than in the lower lip. They metastasize quicker and may go directly to the upper cervical region, and to the preauricular nodes of the parotid as well as the submaxillary region, and are usually widespread in these areas.

Treatment is by radiation. The spindle cell type and salivary tumors are best treated by surgical excision. The prognosis is not as good as in the lower lip.

### **Carcinoma of Tongue (Anterior 2/3 Rds.)**

Occurs chiefly in men between 40 and 60 years of age. Women account for only about 1/4 or 1/5 of the cases. It is often associated with poor oral hygiene, frequently occurring next to an injuring carious tooth. About half of cases have a coexisting leucoplakia.

Carcinoma arises most frequently on the lateral border. A small proportion arise on the tip or its ventral surface. In general there is a diffuse induration beneath the leucoplakia.

Some lesions are predominantly infiltrating, with little or no ulceration, while others may be extensively ulcerated, with or without deep infiltration. Those on the ventral surface extend to the floor of the mouth and it may be difficult to determine its true origin. The tip lesions are usually ulcerated with little infiltration.

The most common symptom is a growth or very slight local pain. When the tumor becomes ulcerated and secondarily infected, otalgia on the same side as the lesion, hypersalivation and dysphagia may occur. Except in the very early stages, pain is a predominant and important symptom. It may become excruciating and radiate to the entire side of the face and head.

Adenopathy is present in about 40% of cases on initial examination, and about 40% of those without nodes when first seen develop them later. The longer the lesion is present, and the larger the tumor, the greater the chance for metastatic nodes.

Metastatic nodes from carcinoma of tongue are most common in the upper cervical region below the angle of the mandible. Less frequently the submaxillary region or lower cervical nodes are involved. The metastatic nodes are usually not very large, but are multiple, and are frequently bilateral.

The diagnosis is made from the history, and by careful palpation of the tongue and visual description. A biopsy with a scalpel should be taken, and should include not only some of the border ulceration, but also some of the adjacent normal mucous membrane. A suture or two will be necessary to control the bleeding in an adequate biopsy. Leucoplakia and syphilitic chancre are chief in the differential diagnosis. Dark field examination of lesion should always be accompanied by biopsy because of the frequent coexistence of syphilis and carcinoma of the tongue.

### **Treatment**

Interstitial curietherapy is the most effective treatment in the majority of cases. This consists in the introduction of sources of radiation, either radium itself or radon seeds into the substance of the tumor. The technique is difficult. Radium needles are preferred over radon seeds.

Roentgentherapy helps reduce the secondary infection, but it rarely eradicates

entirely the carcinoma. It should be used as an adjunct to the interstitial curietherapy.

Surgical treatment of the primary lesion is not always successful and is mutilating with the resulting loss of function of the tongue. However, radical neck dissection is the treatment for metastatic cervical adenopathy. This implies a complete block excision of the submaxillary content, the sternocleidomastoid, the internal jugular vein, the nodes, fat, connective tissue surrounding them, from the mandible to the clavicle.

Bilateral radical neck dissection may be necessary for bilateral metastasis. A prophylactic neck dissection in the absence of palpable nodes has unquestionable merits, and should be done after the treatment of the primary carcinoma of the tongue.

Prognosis varies with the adequacy of the treatment, ranging from 8% five year cures to 27% three year cures.

### **Carcinoma of Floor of Mouth**

These carcinomas account for about .5% of all cancers, and about 17% of all oral carcinomas. They originate to the side of the midline, and may present only a deep fissure ulceration, or the entire area may be ulcerated. They extend rapidly and adhere to the inner aspect of the mandible.

They metastasize to the submaxillary nodes, at times to the anterior jugular chain of nodes and are apt to be bilateral.

The most common symptom is an indurated mass felt by the tip of the tongue. After the tumor is ulcerated, otalgia, hypersalivation and difficulties with speech occur. Mild bleeding may be noticed.

These tumors are to be distinguished from chronic inflammatory obstruction of submaxillary or sublingual ducts; there is no ulceration in these. Salivary calculus should offer no problem.

### **Treatment**

- (1) Surgical excision offers little hope, they invariably recur.
- (2) Roentgentherapy rapidly decreases the size of the tumor and the secondary infection, but external radiation alone seldom causes a permanent control of the lesion.
- (3) Radium has been considered the treatment of choice, either with superficial curietherapy or with

interstitial curietherapy. Necrosis of floor of mouth or mandible is usually an unavoidable complication, but should not contradict the use of curietherapy.

The treatment of the cervical adenopathy is again radical neck dissection. Prophylactic neck dissection is justifiable.

Prognosis of carcinoma of floor of mouth is more favorable than carcinoma of tongue, ranging from 17% five year cures to 45% three year cures.

### **Carcinoma of Buccal Mucosa**

This occurs about 1/3rd to 1/4th as often as carcinoma of the tongue, with an average age of 64 years and males outnumbering females 10 to one.

These tumors arise on the buccal aspect of the cheek, usually opposite the 3rd lower molar; and are usually preceded by leucoplakia. They are usually of the papillary type, but at times present ulcerating lesions.

They metastasize to the submaxillary nodes and seldom to parotid region.

The onset is usually slow, with deep infiltration. Submaxillary nodes may be the first clinical symptom. Pain is present and severe in the ulcerating type. The papillary type grow larger and may interfere with mastication.

### **Treatment**

Roentgentherapy alone gives inconstant results, but it is a valuable adjunct.

Radium packs offer no more than external irradiation.

Interstitial radiation offers the best results.

**SURGERY:** Early excision in small lesion is good. For advanced ulcerating lesions, the best procedure is an en-bloc radical excision of the tumor and its adenopathy and at times a radical resection of the mandible.

**PROGNOSIS:** Ulcerating lesions give poor results. The papillary type may give up to 38% five year survival.

### **Carcinoma of Upper Gingiva**

These carcinomas are not as frequent as those of the lower gingiva. They occur chiefly in men, are usually of the papillary type. They occur chiefly over molar and premolar areas. They extend to the palate and to the floor of the maxillary antrum.

They metastasize to submaxillary nodes,



and only occasionally to upper cervical nodes. The metastases are seldom bilateral.

These carcinomas are usually noticed because of ill-fitting dentures, or because of ulceration around the teeth. Otalgia may occur when secondary infection is present.

It may be extremely difficult to establish whether the tumor originated in gingiva and spread to palate, or whether the process began in the antrum and spread to the mouth. The presence of nasal bleeding or nasal obstruction may help in the differentiation. X-ray examination will show the extent of bone destruction. Several benign tumors must be differentiated.

Epulis are usually shiny, grow around the teeth, vary in consistency; do not ulcerate unless teeth have been extracted.

Fibrous epulis is usually pedunculated.

#### **Treatment**

Surgery is the method of choice. This implies the radical resection of parts of palate, maxilla and any involved bone.

Radiotherapy is an adjunct to the treatment.

#### **Carcinoma of the Lower Gingiva**

These constitute about 5% of oral cancers. They arise in the molar areas usually, and occasionally in the fore part of the mouth. They are usually associated with lymphadenopathy, which is unilateral, unless the tumor has involved the floor of the mouth. The submaxillary nodes are the most often involved, followed by the anterior jugular chain.

These tumors are usually first recognized because of ill-fitting dentures, or because of bleeding on mastication. Otalgia accompanies infection. Trismus may occur. The lesion is usually a rubbery growth, at times ulcerated and exposing the mandible. There is often a tumefaction of the lower cheek, adhered to skin, which often ulcerate.

X-ray examination must be done in all gingival carcinomas to note the amount of bone invasion. A negative X-ray does not mean the lesion has not invaded the bone.

#### **Treatment**

Roentgentherapy, both external and peroral have been successful at times. This form of treatment is usually only justified in early cases.

#### **Surgery**

Local excisions are usually not enough, and are justified only if the lesion is on alveolar ridge.

The usual treatment demands a radical resection including the entire half of the mandible, together with a radical neck dissection.

Prognosis ranges from 24% five year survivals to 45% three year survivals.

#### **Tumors of the Hard Palate**

The majority developing here are of the mucous and salivary gland type, and often grouped together as mixed tumors. They usually occur in the posterior half of the hard palate, in general, are well encapsulated and lobulated. They may extend into the soft palate, and invade into the nasopharynx, or may invade the maxillary bone, maxillary antrum or floor of the nasal fossa. They have little tendency to ulcerate till quite late.

The malignant tumors of palate seem to metastasize only after years of development (average duration of five years) and then seem to spread by blood stream, rather than by the lymphatics.

#### **Treatment**

The salivary and mucous tumors, whether benign or malignant, require surgical excision, especially in the young. In the aged, abstention may be tolerated. The removal usually implies removing part of hard palate, with a resulting permanent opening into the antrum or nasal fossa. Radiotherapy has little benefit.

#### **Prognosis**

Depends on the type of tumor and is usually very good. The rare epidermoid carcinoma of the hard palate with ulceration, offers a much poorer prognosis.

#### **Comment**

A brief description of oral carcinomas has been presented, together with the treatment and prognosis.

## BRONCHIECTASIS IN CHILDHOOD

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Bronchiectasis is a chronic, progressive inflammatory disease of the bronchi and their supporting tissues, resulting in denudation and dilation of the affected bronchi which serve as reservoirs for the constantly accumulating pus.

Bronchiectasis was first described as a disease entity by Laennec in 1819. For nearly a century, however, positive recognition of the condition was possible only at the autopsy table. When Chevalier Jackson in 1918 demonstrated that the bronchial caliber in the living patient could be determined roentgenographically by the use of insufflated barium powder as a contrast medium a new era in diagnosis was ushered in.

### Etiology

The etiology of bronchiectasis is undoubtedly manifold, there being no one condition which is responsible for its development. The condition is much more common in children than is ordinarily recognized, and is occasionally seen in infants. There is some question about the existence of congenital bronchiectasis but at least certain congenital anomalies such as pulmonary cysts, the persistence of fetal atelectasis, and infection following the aspiration of amniotic contents during birth are possible contributing factors. Another contributory factor is the respiratory disturbance associated with cystic fibrosis of the pancreas. In 1933 Kartagener described an association of sinus abnormality, bronchiectasis, and transposition of the viscera which has since been known as Kartagener's syndrome. Among 85 persons with congenital dextrocardia Olsen reported that 16.5 per cent also had bronchiectasis. Approximately forty per cent of all cases of bronchiectasis have their onset in the first decade of life and another twenty-five per cent in the second decade. The majority of these cases date to attacks of such diseases as pneumonia, influenza, measles, and pertussis.

### Classical Changes

Riggins points out that in the classical case of bronchiectasis the early changes

which later lead to the dilatation of the bronchi nearly always involve the bronchial mucosa and submucosa as well as the lung parenchyma. With repeated attacks of bronchopneumonia the chronic inflammatory changes progress in the mucosa and submucosa. The cough and other symptoms of chronic bronchitis may subside in the warm months but still the involved lung does not return to normal. With recurrence of acute infection the chronic inflammatory changes progress until there exists extensive irreversible fibrosis of a part of an entire lobe. Fibrous tissue replaces muscle bundles and elastic fibers. Thus the bronchial walls are weakened following which coughing may result in dilatation of the bronchi. New areas of bronchiectasis may be formed as well as an increase in fibrosis, emphysema, atelectasis, and pneumonia.

Any condition which causes bronchial stenosis or obstruction such as foreign bodies, tumors, enlarged lymph nodes, and fibrosis caused by such conditions as tuberculosis, etc., may result in retention of excretions which become infected and give rise to lung abscess, bronchopneumonia, and later indurative pneumonia and bronchiectasis.

Riggins is of the opinion that atelectasis is not the primary etiologic or pathogenic factor in the development of bronchiectasis. He believes that the development of a collapsed lobe is a late manifestation of a disease process which has gradually led to the development of pulmonary fibrosis and bronchiectasis and therefore is the end result of a protracted, chronic and inflammatory process.

Following impairment of the bronchial wall dilatation occurs. There is considerable controversy regarding the responsible factors. Dilatation may be caused by stagnant exudate exerting intrabronchial pressure as evidenced by experimental studies of Tannenberg and Pinner. Hedblom and others have suggested that negative intrathoracic pressure may be sufficient to dilate impaired bronchi. When pulmonary alveoli are collapsed the bronchi are thought to dilate ultimately to fill the space.

The role of chronic paranasal sinusitis



as an etiological factor in bronchiectasis is open to question. Many times chronic sinusitis is found in patients with bronchiectasis. In a study of 100 cases of bronchiectasis Riggins found 30 cases of chronic sinusitis. However the symptoms of bronchiectasis preceded the symptoms of sinusitis in about two-thirds of the cases. It must also be borne in mind that while bronchiectasis is a disease of childhood and early adulthood, chronic sinusitis appears later in life.

### **Inflammatory Change**

The pathology varies considerably in various cases and even in the same lung. The dilatations of the bronchi may be cylindrical, fusiform, or saccular and may involve a portion of a lobe, the entire lobe, or multiple lobes. The dilated bronchi are no longer lined by ciliated columnar cells but show ulceration and squamous metaplasia. There are chronic inflammatory changes of the peribronchial tissues with destruction of the elastic and muscular fibers and replacement by fibrosis. Atelectasis and extensive fibrosis of the involved portion of a lung are common sequels. In bronchiectasis there are innumerable minute cavities which are apparently dilatations of the bronchioles producing the so-called "Honeycomb" lung.

### **Symptoms**

The onset rarely is abrupt and usually follows, with or without an intervening latent period, some other disturbance of the respiratory tract. The development of bronchiectasis is a slow process usually extending over a period of months to as much as several years but occasionally may develop in a few weeks. When fully developed about the only constant symptoms are a chronic cough and the expectoration of a purulent sputum. The course is characteristically progressive but there are frequent periods of remission and exacerbation. The sputum is purulent or mucopurulent, at times has a foul odor and may be blood-tinged. Hemorrhage is a common symptom and may vary from a small to a large amount. Growth and development are usually retarded in the protracted cases. Dyspnea on exertion is a common complaint and infrequently there is intermittent pain in the chest. Children with bronchiectasis often have repeated acute episodes which may be variously diagnosed as pleurisy, influ-

enza, pneumonia, or whooping cough. The temperature is usually elevated during these acute exacerbations.

The cough and expectorations have a tendency to be initiated by a change of position such as stooping over, lying down, or turning over. The paroxysms are initiated apparently by the shifting of accumulations of exudate into new positions thus irritating the bronchi.

### **Physical Signs**

The physical signs are variable. There may be none particularly during a quiescent stage. Often, however, coarse rales can be heard over the involved area and even over the other dependent portions of lung. If fibrosis and contracture are present, dullness to percussion and harsh breath sounds may be found. If there is atelectasis there will be a suppression of breath sounds. When there is marked saccular dilatation the breath sounds may be amphoric during the intervals when the dilated tubes are empty. Clubbing of the fingers is frequently present in long standing cases and various degrees of anemia are commonly found.

### **Bronchoscopy**

Bronchoscopy is an essential step in the diagnosis of bronchiectasis to determine the existence of bronchial stenosis, tumor, compression or foreign body and to obtain secretions for culture and tests for susceptibility of the organisms to the antibiotic agents. An adequate evaluation of the patient must include examination for infected foci such as sinusitis, infected tonsils, and oral sepsis.

Fluoroscopic examination is valuable in the determination of the diagnosis of bronchiectasis. It will help in locating areas of emphysema and also if there is atelectasis the mediastinum will shift to the involved side.

### **Diagnosis**

The diagnosis of bronchiectasis can be established with certainty only by roentgenographic examination of the lungs after the instillation of lipiodol. The lipiodol must be injected into all lobes of both lungs because otherwise an area of bronchiectasis may be overlooked. Not infrequently bilateral bronchiectasis is present and occasionally four or five lobes may be involved.

### Treatment

The treatment of bronchiectasis is medical and surgical. In the very mild fusiform bronchiectasis with little or no symptomology conservative methods may and should be given a fair trial. These consist of:

1. Elimination of foci of infection such as sinusitis, chronically infected tonsils, etc.
2. Avoidance of respiratory infection and irritant dust and gases.
3. Use of postural drainage.
4. Bronchoscopic drainage at frequent intervals to assist evacuation of purulent material.
5. Aerosol inhalation of antibiotics. The use of a broncho-dilator before aerosol antibiotic therapy is useful. One such agent is Norisodrene, made by the Abbott Co.
6. Oral or parenteral administration of antibiotics such as penicillin, streptomycin, Aureomycin, etc.
7. Maintain or improve the general health of the patient with adequate diet, vitamins, etc.
8. Change of climate if possible to avoid repeated respiratory infections.

However, medical therapy is of little help in the well-established cases. The only method of treatment in these cases is the surgical removal of the diseased

portions of the lungs. Dr. Marc Reardon will discuss the surgical therapy shortly.

### Prognosis

The prognosis of bronchiectasis is good if adequate therapy is instituted. Children who have had one or even two lobes do well. They are able to participate in all usual childhood activities and can lead normal healthy lives.

If the diseased lung structure is removed and such other contributing factors as infected tonsils, sinusitis, etc., are controlled it is unusual for bronchiectasis to recur.

The discussion hardly would be complete unless we include a few words concerning the prophylaxis of bronchiectasis. Inasmuch as bronchiectasis is nearly always secondary to some other condition it is important to prevent recurrent upper respiratory diseases, sinusitis, pneumonia, and the pulmonary complications of measles, and whooping cough. When these diseases do occur prompt treatment should be instituted. All children should be immunized against whooping cough and the use of measles immune globulin and antibiotics will help prevent pulmonary complications of measles.

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**Fresh Cabbage Juice hastens healing of peptic ulcers**, says Cheney, of Stanford University. In 11 of 13 cases treated with cabbage juice, craters disappeared within 9 days. One case required 14 days; another 32. Each patient drank a quart of juice daily, average healing time for 7 cases of duodenal ulcer was 10.4 days and for six cases of gastric ulcer 7.3 days—4½ lbs. cabbage yields 1 qt. of juice. (Southern Medicine & Surgery, S. C., N. C. & Va.) June, 1949 issue.

**Mortality from tuberculosis in the United States** continues to decline. The death rate in 1946 in metropolitan New York was 33 in the white population and 158 in the colored. The combined death rate for the recorded mortality for New York City for 1946 was 41.7 as compared with 45.4 the year previous, a de-

cline of 8 per cent—one of the largest in years. The incidence rate during the 1942-1946 period varied all the way from 47 per hundred thousand in the Gravesend Health Center District of Brooklyn to a rate of 380, almost eight times as great, in central Harlem. Current Comment, J.A.M.A.

**Ignored tuberculosis progresses.** An organized regimen, active treatment, awareness of the possibilities and cooperation are necessary to cure or check the disease. Sarcoidosis may be entirely ignored, and with few exceptions the patient does just as well, or better, than with medical intervention. There is an environmental and family factor in tuberculosis. Great stress is laid on finding the infection source—the contact. Henry E. Michelson, M. D., J.A.M.A., April 17, 1948.



# *The* JOURNAL *of the* Kentucky State Medical Association

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## COUNTY SOCIETY OFFICERS CONFERENCE

The County Medical Society is the foundation upon which the structure of organized medicine stands—or falls. The extent to which the county society fulfills its purpose depends largely upon the leadership of its officers.

The state association is keenly conscious of its need for the active support of county societies. There should be no programs at the state level that are not in concurrence with the thinking of members at the local level, and which do not merit the support of every member.

Recognition of the need for unification of the state association and the county societies into one closely knit organization seeking mutual objectives has resulted in planning the First Annual County Society Officers Conference. It is an effort to utilize the potential strength of these leaders of medicine.

The meeting will afford an opportunity to discuss and to hear discussed some of

the more serious problems confronting the profession. An exchange of views and ideas is always of value in planning and executing any program. Certainly it will result in fuller understanding of what the state association is trying to accomplish. These objectives are set by the House of Delegates or by the Council and often there is too little explanation to the membership through the county societies. This situation can be corrected by close liaison between the two levels. Fuller understanding will inevitably result in closer cooperation.

The ultimate goal is a united profession harmoniously working together at all levels for common objectives for the mutual good of each member of the association, and for the profession as a whole. The Conference is a step toward this goal.

We hope that a large percentage of the Officers of county societies can find the time to attend this important meeting.

## CIVIL DEFENSE

Wars bring more hardships to the medical profession than perhaps to any other. A large number of physicians are required by the military to care for the wounded and the sick and to provide preventive services for the well. The civilian population continues to need medical care in time of war which must be provided by those physicians who remain.

To these demands the profession has responded with honor in all of the wars in which our country has engaged. With the advent of atomic warfare, however, new problems appear upon the horizon. These require careful planning and organization of the profession, both in target areas and elsewhere.

The fact must be recognized that a large percentage of the physicians and hospital facilities in a target area may be wiped out. In such an event a large part of the medical care of the thousands of casualties would have to come from physicians in other areas. The state then is naturally divided into target areas and mutual aid areas, each requiring different types of civil defense organization.

Following the national pattern of civil defense organization, Governor Clements appointed Dr. Bruce Underwood, State Commissioner of Health, as Medical Director of Health Services for Civil Defense, who in turn appointed Dr. P. M. Crawford as Deputy Director and all local Health Officers as Directors of Health

Services for Civil Defense in their respective counties.

The huge task of civil defense requires a training program as well as organization. Both are well under way at the time this is being written. The initial course for physicians in the Louisville area is scheduled for January 24 and 25 with lecturers from the Medical Department of the U. S. Army, Fort Knox, who have been trained by the Department of Defense. The course was planned in cooperation with the Jefferson County Medical Society. Similar courses will be provided in the near future in fifteen other Kentucky cities for the benefit of physicians in those areas.

Five Kentucky nurses have completed the training course on nursing aspects of atomic warfare which was planned by the National Security Resources Board and held in Atlanta, Georgia. The services of these nurses will be utilized for special instruction of the nursing profession of Kentucky.

Dr. Crawford, who at present is Director of the Division of Tuberculosis Control of the State Department of Health and is a retired Medical Officer of the U. S. Army, is giving much of his time to planning the organization of Kentucky health resources for Civil Defense. He states that a suggested plan for local organization will soon be forwarded to each county.

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## PRESENT VA POLICY ON USE OF CORTISONE AND ACTH

Dr. O. P. Miller, Chief Medical Officer of the Louisville Regional Office of the Veterans Administration, has been notified that existing regulations pertaining to the use of Cortisone by V.A. participating physicians has been modified. The Agency's action followed the change in the Food and Drug Administration's policy which permits Cortisone and ACTH to be dispensed upon physicians' prescriptions.

The new policy follows:

a. The initial course of treatment with Cortisone or ACTH must be given in a Veterans Administration Hospital.

b. Veterans Administration Hospitals will

appoint a Committee of Physicians on Cortisone and ACTH. These hormones will not be used on any patient without the approval of the Committee.

c. When veterans have received maximum benefits from hospitalization for a service-connected condition and are ready for discharge, the Committee will determine whether or not maintenance therapy on an out-patient basis is warranted, and if so, prepare definite recommendations to that effect and the maintenance dosage. The Committee will prepare specific instructions for a patient receiving Cortisone and ACTH treatment. The patient will be recalled by the Veterans Administration Hospital



within three months for follow-up examination and a determination as to the advisability of continuing the therapy. It must be remembered that out-patient treatment is limited by law to service-connected and/or adjunct conditions.

d. Cortisone or ACTH therapy may be continued for a service-connected and/or adjunct condition at Regional Offices following an initial course of therapy in a hospital if so recommended by the hospital.

e. When extenuating circumstances prevent the veteran from visiting the Regional Office for maintenance therapy, treatment with Cortisone or ACTH may be authorized to fee-basis physicians under the following conditions:

(1) A copy of instructions giving the dosages recommended by the Cortisone and ACTH

Committee will be forwarded to the fee-basis physician.

(2) Fee-basis physicians selected by the Area Medical Director and the veteran will be required to forward prescriptions to the Regional Office for filing. **PRESCRIPTIONS WILL NOT BE WRITTEN BY FEE-BASIS PHYSICIANS FOR COMPOUNDING BY RETAIL PHARMACIES AT GOVERNMENT EXPENSE.**

(3) Fee-basis physicians providing maintenance therapy to veterans will be required to submit detailed progress reports at monthly intervals to Regional Offices on all veterans so treated.

(4) It is emphasized that fee-basis physicians will not use CORTISONE or ACTH on eligible veterans without prior approval of the Regional Office.

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## THE DOCTOR AND HIS PATIENT

Last summer we heard Dr. Roscoe Miller, Dean of Northwestern University School of Medicine, express the opinion that in the senior year of medical school there should be some sort of a course that would reassemble all of the various tissues and organs of mankind into a human personality in the thinking of the medical student.

The profession is beginning to realize that the present system of medical education tends to produce physicians who are pure scientists, primarily interested in the patient as a challenging medical problem.

Some physicians, unfortunately, take much the same attitude toward a patient that a research bacteriologist has toward an interesting micro-organism which he has under observation.

Forgotten, too often, are the human and sociological aspects of the patient's condition, which may be as great a menace to his total well-being as the disease itself. The troublesome physical and economic aches and pains are submerged in some doctors' thinking in the problems of diagnosis and therapy.

It is readily admitted that such an efficient scientific approach may successfully combat the pathological process. Although the patient may grudgingly acknowledge Dr. X's scientific skill, when he reviews his experience in retrospect, Dr. X may not have gained a friend

for himself and may have made an enemy for the profession.

Sometimes there is an unitemized statement—Professional Services \$xxx.xx. It seems to the patient to be excessive. He wonders, "How much for x-rays?", "How much for laboratory tests?", "Does the doctor get it all?"

Perhaps there was no explanation or discussion of the patient's condition. Maybe the doctor was busy and the symptoms were vague and the patient was brushed aside as neurotic and hence unimportant. Perhaps there was no attempt at sympathetic understanding of the patient as a person.

There is more involved in this trend toward ultra-scientific "men-in-white" than an evolution from the traditional "bedside manner." Surveys have shown that patients definitely do not like it. Hence it points up one of the public's dissatisfactions with present medical care. Although in politically dominated medicine, medical care would inevitably tend to become wholly impersonal the point is that dissatisfied people are willing to try any sort of change.

As an evidence of public interest in this phase of medical care, "Time" (October 2, 1950) discussed the problem in connection with a review of a new book, "Principles of Internal Medicine" (Blakiston), edited by Tinsly R. Harrison, M. D.

The American Medical Association is

taking the lead in re-establishing good public relations for the profession. The 12-point program identifies the objectives of the professional as a whole with the public good.

Each individual physician should examine his own relations with his patients and take the necessary time to include sympathetic interest and human understanding in his modern armamentarium.

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## EDITORIAL COMMENTS

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**In the Health Services and Special Weapons Defense** handbook recently released by The Federal Civil Defense Administration, it is estimated that in an American city an atomic bomb would produce a total of approximately 120,000 casualties. It is expected that 40,000 would be killed outright or die the first day. An additional 20,000 would die during the following 5 or 6 days.

Surviving the first 24 hours would be 80,000 injured who would require medical attention. Of these, 48,000 would be suffering from burns; 40,000 from mechanical injuries due to falling walls, flying glass and other objects. Many of these would have fractures. Approximately 16,000 would be suffering chiefly from radiation sickness.

The total of more than 80,000 is due to the fact that many of the casualties would need treatment for more than one type of injury.

**When the Army took over the I. G. Farben plant** in Germany in 1945, it was found that preliminary work had been begun on Methadone, a synthetic narcotic. It has since been perfected by cooperation between the Army and other interested groups.

Dr. Henry K. Beecher, Civilian Consultant to the Army Surgeon General and Professor of Research in Anesthesia at Harvard University Medical School, has observed its use for three years at Massachusetts General Hospital and on hundreds of wounded soldiers in Korea, states that the new drug can replace morphine.

It has the same effect as morphine, milligram for milligram, yet it is said to be less habit forming and produces less nausea.

Methadone, made from nitriles derived from nitrogen and hydrocarbons, has also been tested on morphine addicts in the U. S. Public Health Service Hospital in Lexington.

**Our congratulations go to Dr. Joseph C. Bell**, Louisville Radiologist, upon his election as President-Elect of the Radiological Society of North America.

This high honor is richly deserved by Dr. Bell.

Continued recognition of Kentucky's doctors by National associations brings honor to our State Association and our profession.

**More than 65,000 business firms, organizations and individuals** supported A.M.A.'s advertising campaign by purchasing 1,186,254 lines of tie-in advertising at a cost of \$2,019,849.00.

This action on the part of American business men clearly demonstrates their realization that the threat of socialized medicine casts its formidable shadow across free enterprise.

**The appropriation of \$500,000 by the A. M. A. House of Delegates to Medical Schools** is most praiseworthy. Although it is true that this sum is not sufficiently large to go very far toward solving the problem of financing medical education, it is nevertheless a step in the right direction.

It is to be hoped that the leaders of industry will realize not only the magnitude of the problem but also the fact that they are directly concerned and will follow A.M.A.'s lead.

**Chiropractors are planning a weekly newspaper** to be known as the CHIROPRACTIC CHALLENGER. Eight experimental issues were used to test public acceptance. The result was said to have encouraged an all-out effort to gain a million subscribers within a year. Net proceeds from the publication are to be used by the Committee for Chiropractic Education to convey the "Chiropractic Message" to the public in a nation-wide advertising campaign.



# ORGANIZATION SECTION

## Attendance at Officers Conference To Be By Invitation

The First Annual County Society Officers Conference, to be held Thursday, March 1, 1951, in the Brown Hotel, Louisville, will be an invitational affair, the Council voted at its December 28 session.

All officers and legislative and public relations committee chairmen of each county society are invited. In addition, the chairmen of all K.S.M.A. committees will be invited to attend together with the members of the official family and Council of the Association.

If a county society officer cannot attend the meeting, another member of that county medical society who can attend may be nominated to take his place.

Advance information on the meeting is being sent to the 1951 county medical society officers as their names reach the Headquarters Office. If you have not sent the names of your 1951 county medical society officers to the Headquarters Office, please do so at your earliest convenience.

## State Leaders to Participate in County Officers Program

The County Society Officers Conference, which will be held in the South Room at the Brown Hotel in Louisville, March 1, 1951, will feature a number of our state leaders. (Story on national and out-of-state speakers for Conference will be found elsewhere in this section.)

Sam A. Overstreet, M. D., Louisville, President of the Association, will talk on the subject "Looking Toward the Centennial." In addition, Dr. Overstreet will preside at the morning session. The latest information on the procurement of physicians for military service will be brought by A. Clayton McCarty, M. D., Louisville, Chairman of the Procurement Committee.

The Conference will hear something of the legislative plans that the House of Delegates and Council have been considering, from our Secretary and General Manager, Bruce Underwood, M. D., Louisville. C. C. Howard, M. D., Glasgow, Chairman of the Council, will moderate the question and discussion period of the morning session.

Some of the aspects of the Public Relations program of the K.S.M.A. will be explained by R. Haynes Barr, M. D., Owensboro, Chairman of the Education Campaign Sub-Committee. Clark Bailey, M. D., Harlan, President-Elect of the Association, will preside at the afternoon session. Hugh L. Houston, M. D., Murray, Speaker of the House of Delegates, will moderate the final question and answer session.

## County Society Officers to Hear A. M. A. Washington Director

"The Washington Scene" will be discussed by Jos. S. Lawrence, M. D., Director of the A.M.A. Washington, D. C., office, at the morning session of the County Society Officers Conference, Thursday, March 1, 1951, at the Brown Hotel.

Due to his many connections and intimate associations with people who are making the news, Dr. Lawrence, who edits "Capitol Clinic," will make a very valuable contribution to our program. One of the features of the Conference will be the 30-minute "Stump the Experts" session at both the morning and afternoon sessions. Dr. Lawrence will be available to answer your questions during these periods.

As previously announced, Elmer L. Henderson, M. D., Louisville, will bring greetings from the A.M.A. as its president. He will introduce George F. Lull, M. D., Secretary and General Manager of the A.M.A., who as the luncheon speaker, will discuss "What your A. M. A. Means to You."

Nationally known State Secretaries will take part in our program. The art of working with state and national senators and representatives has received much attention in Ohio. Charles S. Nelson, Executive Secretary, will tell us how Ohio's county medical societies organized for their successful efforts in working with legislators.

The Indiana State Medical Association has had one of the more successful public relations programs. One of the interesting aspects of their program has been the securing of more resolutions opposing compulsory health insurance than any other state; also, how these resolutions are used advantageously. Ray E. Smith, Executive Secretary, will discuss "Public Relations in the County Medical Society in Indiana."

### **County Officers Urged to Take Part in Conference March 1, 1951**

Two audience participation sessions have been planned for the day-long County Society Officers Conference to be held in Louisville, Thursday, March 1, 1951, at the Brown Hotel.

There will be no opportunity for discussion or for questioning any individual speaker at the conclusion of his talk. However, the County Society Officers are urged to ask questions at the "Stump the Experts" sessions that will be held at the conclusion of each half-day session. The speakers will be on hand to answer your questions.

Another feature of the Conference will be the individual meetings of the County Officers in each of the 15 Councilor Districts. Each Councilor will use this 25-minute session to transact the business of his District.

Registration for the County Officers Meeting will begin at 9:30 A. M., in the South Room of the Brown Hotel. The program proper will start promptly at 10:00 A. M.

### **Members in Armed Forces Exempted From Payment of Dues**

Members of the Kentucky State Medical Association, who are in good standing at the time they are inducted into the Armed Forces, will not be charged a membership fee while on their tour of military duty.

This motion was unanimously passed by the Council at its December 28, 1950, meeting. The ruling becomes effective on the next billing date for membership dues after the member enters the service. No dues will be returned.

The Council, at the same time, expressed the hope that the component county medical societies would take similar action on this matter.

### **New Group to Facilitate Work of Council Between Sessions**

Setting up an Executive Committee of the Council was one of the many items acted on by the Council in a day-long session that handled a heavy agenda in the Headquarters Office, December 28, 1950.

The By-Laws of the Association provide that the President and Secretary of the Association and the Chairman of the Council will make up the Executive Committee of the Association. R. Haynes Barr, M. D., Owensboro, Councilor from the Second District, and Edward B. Mersch, M. D., Councilor of the Eighth District, were elected to serve with this group

which, with these additions, will be known as the Executive Committee of the Council.

This committee was set up to facilitate the activities of the Council and to work with the Secretary and General Manager of the Association between sessions of the Council. The next regular meeting of the Council has been set for May 10, 1951.

### **President's Appeal for More 1950 A. M. A. Members Productive**

A total of 75 K.S.M.A. members who had not remitted their 1950 A.M.A. dues responded to the letter which Sam A. Overstreet, M. D., Louisville, President, sent out December 16, by paying their 1950 A.M.A. membership fee.

The Boyd County Medical Society sent in the largest number at any one time of any of our components, when twenty names were reported with remittances to cover the 1950 national fee.

Dr. Overstreet has expressed himself as being pleased with this response. He feels, however, in view of the excellent contribution the A.M.A. has made both to the public and to the profession, it should draw greater support from the members of our Association.

A total of 1348 of our members, or 69 per cent, have now paid 1950 A.M.A. dues. The A.M.A. membership fee in 1951 is \$25.00 and includes an annual subscription to the weekly national journal. The 1951 A.M.A. dues cannot be accepted until your 1950 membership fee has been received.

Five states make A.M.A. membership mandatory. Kentucky is below the average of the other progressive state medical associations in the number of its members who join the A. M. A. voluntarily.

### **Centennial to Feature Program of Ky. Born or Trained Doctors**

The scientific program of the Centennial Meeting of the Association, to be held in Louisville, October 2, 3 and 4, 1951, will be made up entirely by outstanding Kentucky-born or Kentucky-educated physicians from other states.

The Council, meeting in Louisville December 28, 1950, approved the recommendation, presented by Sam A. Overstreet, M. D., Louisville, and made jointly by the Centennial Committee and the Committee on Scientific Assembly, calling for this kind of a program.

Dr. Overstreet, who is chairman of these committees, reported at some length on the



various features that are being planned for this unusually interesting and attractive meeting. In addition to these committees, many sub-committees are making plans for outstanding supporting features, Dr. Overstreet told the Council.

### **Council Outlines Official Policy on Operations of Hospitals**

The operation of the administrative affairs and the participating and visiting staffs of hospitals built in Kentucky with public funds obtained from local, state, and national sources, were discussed at the December 28, 1950 meeting of the Council.

The Council, feeling that the Kentucky State Medical Association should express itself on this matter, adopted the following motion as its official policy:

"The Association feels that these hospitals were built for the benefit of the residents of the county and surrounding communities, and for the physicians in these boundaries treating the sick. It believes that the hospital should be operated and controlled by a board, whose members are residents of the county in which the hospital is located, and that the superintendent and administrator of the hospital should be residents of said county.

"The Association feels that the participating staff of the hospital should be composed of qualified physicians who are residents of the county and that the visiting staff should be made up of qualified physicians in surrounding

communities who wish to use the hospital. The Association strongly believes that physicians who live at considerable or great distances should not be allowed to practice in these hospitals except as consultants."

### **Professional Relations Committee New Name of Grievance Group**

"Professional Relations Committee" is the new name of the group originally called the Grievance Committee, when activated by the Council in December, 1949.

The new name was given to the group by the Council at the December, 1950, meeting, when the committee officially petitioned the Council to change its name.

The Council accepted another recommendation of the Professional Relations Committee, which now automatically makes the five-year man on the committee, the chairman.

When the committee was set up, the Council provided that the five immediate past-presidents of the Association would make up the membership of the committee. The last immediate past-president—or the newest member of the committee—was to serve as chairman.

Under the new ruling, J. Watts Stovall, M.D., Grayson, succeeds Charles A. Vance, M. D., Lexington, as chairman of the committee. Other members of the committee are E. W. Jackson, M. D., Paducah; Guy Aud, M. D., Louisville; and Hugh L. Houston, M. D., Murray.

## **BE SURE THAT THE OFFICERS OF YOUR COUNTY SOCIETY ATTEND THE COUNTY SOCIETY OFFICERS CONFERENCE**

**SOUTH ROOM—BROWN HOTEL  
LOUISVILLE, KENTUCKY                      THURSDAY, MARCH 1, 1951  
REGISTRATION STARTS 9:30 A. M.**

**ON THE PROGRAM ARE:**

**Three A. M. A. Leaders  
Two nationally-known State Association Secretaries  
K. S. M. A. Officers and Leaders  
Two "Stump-the-Experts" Sessions  
Other Features**

### **Dr. Overstreet Announces Committee Appointments for 1950-51 Year**

Sam A. Overstreet, M. D., Louisville, President of the Kentucky State Medical Association, has announced the complete list of committee appointments for the 1950-1951 year. Below the entire list of committees and new personnel is presented:

#### **STANDING COMMITTEES**

##### **Committee on Scientific Assembly:**

Sam. A. Overstreet, Louisville, Chairman  
W. Clark Bailey, Harlan, 3 years (term expires 1953)  
Morris Flexner, Louisville, 2 years (term expires 1952)  
J. Duffy Hancock, Louisville, 1 year (term expires 1951)  
Bruce Underwood, Louisville, Secretary

##### **Committee on Arrangements:**

W. Clark Bailey, Harlan, Chairman  
Charles M. Edelen, Louisville  
Charles F. Long, Elizabethtown  
B. J. Baute, Lebanon  
William H. Pennington, Lexington

##### **Committee on Public Relations:**

Sam A. Overstreet, Louisville, Chairman  
David M. Cox, Louisville, 3 years (term expires 1953)  
R. Haynes Barr, Owensboro, 2 years (term expires 1952)  
Oscar O. Miller, Louisville, 1 year (term expires 1951)  
Bruce Underwood, Louisville, Secretary

##### **Education Campaign Sub-Committee:**

(Has not been appointed)

##### **Committee on Medical Economics:**

G. L. Simpson, Greenville, Chairman  
Carl Norfleet, Somerset  
C. C. Howard, Glasgow  
John E. Haynes, Dawson Springs

##### **Medico-Legal Committee**

J. B. Lukins, Louisville, Chairman  
Woodford B. Troutman, Louisville, Ex-officio  
Bruce Underwood, Louisville, Ex-officio  
W. Clark Bailey, Harlan, Consultant  
Lanier Lukins, Louisville, Consultant

##### **Committee on Medical Education:**

Thornton Scott, Lexington, Chairman  
Malcolm D. Thompson, Louisville  
Guthrie Y. Graves, Bowling Green  
Herbert L. Clay, Jr., Louisville  
J. Murray Kinsman, Louisville  
W. W. Nicholson, Louisville

#### **SPECIAL COMMITTEES**

##### **Committee for the Centennial Meeting:**

Sam A. Overstreet, Louisville, Chairman  
Richard R. Slucher, Buechel  
W. Clark Bailey, Harlan  
William R. McCormack, Bowling Green  
J. Duffy Hancock, Louisville  
Emmet F. Horine, Brooks  
R. Haynes Barr, Owensboro

##### **Committee on Emergency Medical Service:**

Pat R. Imes, Louisville, Chairman  
Guthrie Y. Graves, Bowling Green  
Orion L. Higdon, Paducah  
W. Mountjoy Savage, Maysville  
Leland E. Payton, Lynch  
Francis M. Massie, Lexington

##### **Grievance Committee:**

J. Watts Stovall, Grayson, Chairman  
E. W. Jackson, Paducah  
Guy Aud, Louisville  
Charles A. Vance, Lexington  
Hugh L. Houston, Murray

##### **Committee on Hospitals:**

Sam H. Flowers, Middlesboro, Chairman  
Joseph C. Bell, Louisville  
B. Earl Caywood, Danville  
Rankin C. Blount, Lexington

##### **Committee on McDowell Memorial:**

Charles A. Vance, Lexington, Chairman  
J. Rice Cowan, Danville  
George M. McClure, Danville  
Emil Novak, Baltimore, Maryland  
Thomas Meredith, Harrodsburg  
Russell Starr, Glasgow  
Lamen A. Gray, Louisville  
Irvin Abell, Jr., Louisville  
E. Murphy Howard, Harlan

##### **Committee on Nurse Training:**

W. O. Johnson, Louisville, Chairman  
W. Vinson Pierce, Covington  
Charles B. Stacy, Pineville

##### **K.S.M.A. Pharmacy Committee:**

Ben H. Hollis, Louisville, Chairman  
Thornton Scott, Lexington  
W. Keith Crume, Bardstown  
Hugh L. Houston, Murray

##### **Committee to Study Revision of the Constitution and By-Laws**

Guy Aud, Louisville, Chairman  
R. Haynes Barr, Owensboro  
Charles B. Stacy, Pineville  
Hugh L. Houston, Murray  
Bruce Underwood, Louisville



**Kentucky Procurement Committee for Military Service:**

A. Clayton McCarty, Louisville, Chairman  
 J. Duffy Hancock, Louisville, Vice-Chairman  
 Charles B. Billington, Paducah  
 Glenn U. Dorroh, Lexington  
 R. Arnold Griswold, Louisville  
 L. O. Toomey, Bowling Green  
 John L. Walker, D.D.S., Louisville, Sub-Chairman  
 Frank W. Jordan, D.D.S., Louisville  
 E. C. Hume, D.D.S., Louisville

**MEDICAL CARE ADVISORY COMMITTEES****Committee on Cancer:**

Guy Aud, Louisville, Chairman  
 Jesshill Love, Louisville  
 John W. Meredith, Scottsville  
 J. Farra Van Meter, Lexington

**Committee on Crippled Children:**

K. Armand Fischer, Louisville, Chairman  
 Charles C. Carr, Lexington  
 Charles F. Wood, Louisville  
 Hal E. Houston, Murray

**Committee on General Practice:**

Charles G. Bryant, Louisville, Chairman  
 Travis Pugh, Bowling Green  
 William M. Brown, Corbin  
 John W. Somerville, Maysville

**Committee on Industrial Medicine and Surgery:**

Gradie R. Rowntree, Louisville, Chairman  
 R. W. Robertson, Paducah  
 Clyde C. Sparks, Ashland  
 Ira N. Kerns, Louisville

**Committee on Mental Hygiene and Mental Institutions:**

Spafford Ackerly, Louisville, Chairman  
 George H. Wilson, Lexington  
 A. M. Lyon, Frankfort  
 Billy K. Keller, Louisville  
 C. C. Howard, Glasgow  
 John P. Bell, Louisville

**Committee on Obstetrics:**

Rudy Vogt, Louisville, Chairman  
 Coleman McDevitt, Murray  
 Stanley Parks, Lexington

**Committee on Pediatrics:**

James H. Pritchett, Louisville, Chairman  
 William W. Nicholson, Louisville

Robert L. Biltz, Newport  
 Lon C. Hall, Paintsville

**Committee on Physical Therapy:**

Owen B. Murphy, Jr., Lexington, Chairman  
 Richard Hudson, Louisville  
 Robert Hahs, Murray  
 Gordon Buttorff, Louisville  
 McDaniel Ewing, Louisville  
 W. K. Massie, Lexington

**Committee on Rural Health:**

Walter L. O'Nan, Henderson, Chairman  
 Harry K. Dillard, Warsaw  
 Charles B. Johnson, Russell

**Committee on Syphilis Control:**

Oscar E. Bloch, Jr., Louisville, Chairman  
 C. C. Barrett, Lexington  
 William Lamb, Louisville

**Committee on Tuberculosis:**

E. R. Gernert, Louisville, Chairman  
 E. J. Murray, Lexington  
 L. O. Toomey, Bowling Green  
 T. Ashby Woodson, Louisville  
 Col. P. M. Crawford, Louisville

**OTHER ADVISORY COMMITTEES****Committee on Woman's Auxiliary:**

W. Clark Bailey, Harlan, Chairman  
 J. B. Lukins, Louisville  
 Bruce Underwood, Louisville

**Committee on United Mine Workers Health and Welfare Fund:**

C. D. Snyder, Hazard, Chairman  
 Robert S. Howard, Harlan  
 Carl Fortune, Lexington  
 Adam Osborn, Pikeville  
 Charles Yancey, Hopkinsville

**OTHER CONVENTION COMMITTEES****Committee on Technical Exhibits:**

Carlisle R. Petty, Louisville, Chairman  
 J. Spalding Abell, Jr., Louisville  
 Clyde H. Foshee, Louisville  
 E. L. Shiflett, Louisville  
 Arthur T. Hurst, Louisville

**Committee on Scientific Exhibits:**

E. L. Pirkey, Louisville, Chairman  
 D. Woolfolk, Barrow, Lexington  
 Harold Gordon, Louisville  
 Charles F. Wood, Louisville  
 Jesshill Love, Louisville

## KENTUCKY PROCUREMENT COMMITTEE INFORMATION

by

**A. Clayton McCarty, M. D., Chairman**

### **Apply for Commission Before Draft Call, Top Officials Advise**

Most physicians in Priority I under the "Doctor Draft" Law will be called into the Armed Forces by April 1, 1951, and if the international picture darkens, the priority will be exhausted shortly thereafter.

This statement was made by top spokesmen of the Department of Defense and Selective Service before representatives of the state advisory committees' meeting in Washington, D. C., January 12 and 13, 1951.

The session was sponsored by the National Advisory Committee, of which Howard A. Rusk, M. D., is Chairman. Four representatives of the Kentucky State Medical Association attended the meeting.

The state advisory committee representatives were told to urge men in Priority I to apply for a commission in the reserve without further delay. It was stated that applying for a commission at this time does not mean the "special registrant" will be in service any sooner. It was pointed out the men would be called when needed whether in the reserve or through Selective Service.

As was indicated in the January Secretary's Letter, the Kentucky Procurement Committee has been asked to advise with the Armed Forces on the availability of unorganized reserve as well as Selective Service. Therefore, the Kentucky Procurement Committee is in the position to serve the Priority I men, whether they are in the reserve or under Selective Service. The same yardstick used for determining availability by the committee for Selective Service will be used for the reserve.

Interns in Priority I, the conference was told, should apply for their commissions now. They will be allowed to finish their first year of interning as a reserve officer. Residents were also advised to apply for commissions.

A "special registrant" that receives his induction notice forfeits his right to receive the \$100.00 a month bonus. He will be inducted as a recruit. It will then be necessary for him to apply for a commission in the routine way—his application following the usual channels. It would require several months to get a commission in this manner, no bonus would be paid and numerous drawbacks would present themselves.

The state advisory committees were told all of Priority I will be exhausted before Priority II would be drawn up; that all of Priority II would be called before Priority III was approached, etc.

In order to take care of a 3,500,000 man army, the Armed Forces would need 9,000 more physicians by July, 1951. This is in addition to those serving in July, 1950, it was stated.

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### **Procurement Committee Sets Policy on Securing Local Advice**

For purposes of simplicity relative to securing the recommendations of the local communities, the Kentucky Procurement Committee has sought advice from the Councilors of the state. Many have expressed the idea that advice should come from local levels. For example—the president and secretary of the county society. After careful consideration and thought it has been decided to give the Councilors sole authority to secure further advice as they see fit.

This action was taken by the Kentucky Procurement Committee—which was set up under Public Law 779—in an all-day meeting at Louisville, Sunday, January 21. Twenty-seven members of the state and district advisory committees from three professions attended the session. Individuals from the osteopathic and optometry professions sat in on the meeting.



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# *President's Page*

## OUR CENTENNIAL MEETING

Let us begin to plan now to attend and participate in the Centennial Meeting of our Association which will be held in Louisville on October 2, 3, and 4, 1951. The Council has been most generous in approving plans and appropriating sufficient funds to promote what we trust will be the best convention K. S. M. A. has ever held. It will be worthy of the attendance of every member.

We have invited twenty-two out of state doctors to appear on our program. These are all Kentuckians or men educated in our state medical institutions who have distinguished themselves in their respective fields, generally as teachers, in almost as many medical colleges. They will bring the best they can offer to us. We will respond with hospitality and appreciation

and, I trust, the largest attendance on record.

It is planned to prepare a volume commemorative of this occasion. Contained will be a brief biography of Dr. Ephraim McDowell whom we honor this year, a short history of the K. S. M. A., and the presentations of all of our guests and the orations in medicine and surgery. It is not possible to present this volume to each member, but it will be prepared at the most reasonable cost commensurate with the best of workmanship. You will be delighted to add it to your library.

There will be other equally attractive features, but we wish primarily to emphasize our scientific program. Plan now to attend.

*Sam A. Overstreet*

PRESIDENT

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# County Society Reports

## BELL

The regular meeting of the Bell County Medical Society was held at the Bell County Health Office on Friday, December 8, 1950 at 7:30 p. m.

Members present were: Drs. Clyde Russell, Waller Griffing, Fred B. Weller, Arch Carr, Ed Wilson, Sr., C. B. Stacy, C. S. Scott, C. D. Cawood, S. H. Flowers, James Golden, R. F. Porter, Joe Edds, F. Parrott, Ed Wilson, Jr., R. Alford, and Dr. R. G. Talley, Pruden, Tennessee, as a guest.

Dr. Ed Wilson, Sr., reported on the proposal to place furniture in the restored McDowell House. It was proposed that each member donate whatever amount he desired and no flat assessment would be levied. The proposal to have Dr. James Golden's mother inquire in Washington and try to locate something that would be satisfactory was discussed and passed. The minutes of the last meeting were read and approved.

Dr. C. D. Cawood reported on the availability of doctors as set up by the military procurement board.

Annual election of officers for 1951 resulted in the following: President, Dr. James Golden, Vice-President, Dr. Clyde Russell, Secretary-Treasurer, Dr. Fred B. Weller. Delegate to the K.S.M.A., Dr. C. B. Stacy, Dr. C. S. Scott, Alternate.

The question of equalization of fees and professional courtesy in relation to the U.M.W.A. was raised and discussed. A committee consisting of Dr. C. B. Stacy, Chairman, Dr. S. H. Flowers, and Dr. Clyde Russell was appointed to contact Dr. Carl Fortune of the State Committee on U.M.W.A. relations. They are to work out a tentative schedule of professional fees and present their findings at the January meeting.

There being no further business, the meeting adjourned.

Charles S. Scott, Secretary.

## CALLOWAY

At the regular annual meeting of the Callo-way County Medical Society the following officers were elected for the ensuing year: Drs. Hugh L. Houston, President, John C. Quermous, Vice-President, and Conrad H. Jones, Secretary-Treasurer.

Conrad H. Jones, Secretary.

## CARTER

At the regular annual meeting of the Carter County Medical Society the following officers were elected for the ensuing year: Drs. Grady C. Stewart, President, Robert G. Townsend, Secretary-Treasurer. Dr. Stewart was chosen Delegate to the 1951 meeting with Dr. J. Watts Stovall, as Alternate Delegate.

Robert G. Townsend, Secretary.

## CHRISTIAN

At the regular annual meeting of the Christian County Medical Society the following officers were elected for the ensuing year: Drs. D. M. Clardy, President, Norma Shepherd, Vice-President, John Baker, Secretary, Preston Higgins, Treasurer, Guinn S. Cost, Delegate and H. B. Stone, Alternate Delegate.

Gabe Payne, Jr., Secretary.

## DAVIESS

The annual meeting of the Daviess County Medical Society for the year 1950 was held at 7:00 p. m. on December 12, 1950 in the Skyline Room at Gabes. Twenty-four members and two guests were present. Dr. Mack Rayburn, the president, presided.

Minutes of the preceding meeting were read and approved. The annual financial report was read by the Secretary.

The President called upon Dr. C. M. Lacy to introduce his guest, Dr. Ben Stigall, who has recently come to Livermore.

A discussion of the Kentucky Physicians Mutual Insurance by various members of the Society then took place.

Dr. James E. Hix then discussed the drive to situate Kentucky Wesleyan College in Owensboro, and called on the members to support this. He stated that Dr. W. L. Woolfolk and Dr. W. H. Parker had been appointed to contact the members for their contributions toward this cause.

There being no further business the Society proceeded with its annual elections with the following results:

Officers for 1951: President, Dr. F. Hays Threlkel, Vice-President, Dr. Byron Harrison, Secretary-Treasurer, Dr. B. H. Warren.

Delegates to Kentucky State Medical Association for 1951: Drs. Howell Davis, Wm. L. Woolfolk, Alternate Delegates: Drs. James E. Hix, Charles B. Wathen.

R. W. Smith, Secretary.



### GRANT

At the regular annual meeting of the Grant County Medical Society the following officers were elected for the ensuing year:

Dr. Lenora Patrick Chipman, President; Dr. R. E. Kinsey, Vice-President; and Dr. Virginia Kratz, Secretary.

Virginia Kratz, Secretary.

### GRAYSON

At the regular annual meeting of the Grayson County Medical Society the following officers were elected for the ensuing year: Drs. C. L. Sherman, President, W. L. Ozment, Vice-President, J. C. Tucker, Secretary-Treasurer.

J. C. Tucker, Secretary.

### JEFFERSON

The 944th meeting of the Jefferson County Medical Society was held Monday evening, November 20, 1950, at the Seelbach Hotel. Ninety-three members and guests were present for dinner and about fifteen additional for the scientific meeting.

The meeting was called to order at 8:00 p. m., by the President, Dr. J. Andrew Bowen.

Dr. Lanier Lukins introduced the guest speaker, Dr. Edward L. Bortz, Associate Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, and Past President and Past Vice-President of the American Medical Association. Dr. Bortz spoke on "Diabetes Today and Tomorrow."

The business meeting began at 9:05 p. m. Minutes of the last meeting were read and approved.

The Secretary read a letter from Dr. C. H. Eller, Director, Louisville, Jefferson County Board of Health, requesting the Society to appoint a committee to work with the local and state authorities in developing a civil defense program. Motion by Dr. Joseph Bell that such a committee be appointed by the President. Motion carried and seconded. Dr. Bell also recommended that thirty minutes of each meeting of the Society be devoted to plans for defense. Motion seconded and carried. The President proposed to appoint a small committee first who would study the matter and outline the problem, and then act as chairmen of subcommittees to the end that every member of the Society would eventually have some part in this overall plan. The following new members were elected: Drs. George Perrine, Active Membership, and Gene N. Combs, Associate Membership. The President appointed

the following as members of the Nominating Committee: Drs. Frank Stites, Chairman, Louis Baer, Alfred Miller, John Townsend, Thomas Gudex.

Resolutions on the deaths of Drs. L. D. Mason and John D. Allen were read by Dr. Robert C. Long, Chairman, Necrology Committee.

Dr. Ben Hollis gave a report on Diabetes Detection Week. Motion that this report be accepted, was seconded and carried.

Dr. Gradie Rowntree, Chairman, Public Health Committee, reported on action taken by the Committee on a request from the Louisville Optometric Association to make a visual survey of the children in county schools, which was referred to the Committee by the Department of Health. This request was given careful consideration by the Public Health Committee in conjunction with the Louisville Eye and Ear Society and their recommendation that "it would not be wise to divorce the testing of visual function from the general physical examination" was approved by the Judicial Council. Members of the Louisville Eye and Ear Society offered their services to the P.T.A. members, who conduct the visual test, as advisors in any matter of visual testing of school children.

Motion by Dr. E. L. Heflin that these various reports on this subject be approved and filed, seconded and carried.

Dr. H. L. Townsend, Chairman, Professional Service Committee, reported on the request of Miss Marian Spragg, Public Health Nurse, who would like the sanction of the Jefferson County Medical Society in setting up a new type of nursing service for patients referred to her by members of the Society. This service would consist of consultation and advisory service for office patients as well as nursing care in the home. Motion made by Dr. H. L. Townsend that it was the recommendation of the Committee, after an interview with Miss Spragg and study of the matter, that she be given the sanction of the Society to proceed with her plan. Seconded by Dr. Joseph Bell. There was discussion by Drs. C. H. Eller, Lytle Atherton, Louella Liebert, M. H. Boldt, Joseph Bell, Lillian South, and Robert Long, and a standing vote was taken. Motion lost.

The meeting adjourned at 9:45 p. m.

Robert Lich, Jr., Secretary.

### LETCHER

The Letcher County Medical and Dental Society held its regular meeting at the City Hall, Whitesburg, on Tuesday night, December 26th, 1950. The meeting was presided over by its President, Dr. Carl Pigman. The Secretary

being absent, the Chair appointed as its temporary Secretary for the evening, Dr. Billy M. Adams. A quorum was present, and the Society discussed any business matters coming before the Society; a rather lengthy talk was had on the matter of physicians and dentists who might be called into the Armed Services soon from Letcher County; other matters too were brought up.

Since this was the last meeting for 1950, new officers were elected for 1951; without opposition and by acclamation, the following officials will be installed January 1, 1951: Dr. Lundy Adams, Blackey, President, Dr. Lee Moore, Whitesburg, Vice-President, Dr. R. Dow Collins, Whitesburg, Secretary-Treasurer. Elected to the Board of Censors for a 3 year term, Dr. R. Dow Collins, for a 2 year term, Dr. Owen Pigman, for a 1 year term, Dr. B. C. Bach.

Every ethical physician and dentist should take pride to join his local, State and National organization; we regret to learn that there are a few physicians and dentists who have not aligned themselves with their local society and their respective State and National societies; it urged that all who have not done so to date, make preparations to join up within the immediate future.

Dues for 1951 and which will be due January 1, 1951 are as follows (physicians): Local county dues, \$5.00, Kentucky State dues, \$15.00, American Medical dues, \$25.00, or a total of \$45.00 for physicians.

Regular meeting date is the "last Tuesday night of each month," unless otherwise agreed to change.

Scientific program for the January meeting will be a paper by Dr. Billy M. Adams, and an outline for the coming year by the in-coming President, Dr. Lundy Adams. The meeting adjourned at 10:00 p. m.

R. Dow Collins, Secretary.

### MADISON

The annual banquet meeting of the Madison County Medical Society was held December 13, 1950 at the Benault Inn, Richmond. The following officers were elected for the year 1951: President, Dr. M. M. Robinson Vice-President, Dr. J. Bates Henderson, Secretary-Treasurer, Dr. Max E. Blue and Dr. H. H. Rutledge was elected Delegate for a two year term.

Dr. William C. Robinson, Lexington, was guest speaker and his subject was "Bronchiogenic Cancers of Lung." This was a very excellent paper and was freely discussed by those in attendance.

There being no further business, the meeting adjourned.

Max E. Blue, Secretary.

### McCRACKEN

The December meeting of the McCracken Medical Society was held at the Ritz Hotel with Dr. Charles Billington presiding.

The minutes of the November meeting were read and approved. The annual treasurer's report, given by Dr. E. W. Jackson, reflected a balance of \$751.04.

The election of officers was held and resulted in the following: Drs. W. P. Hall, President, Theodore Rosenberg, Vice-President, E. W. Jackson, Treasurer, George H. Widener, Secretary, James A. Ward, Delegate for 1951-52, Leon Higdon, Delegate 1951, Charles Billington, Alternate Delegate for 1951-52, William Eaton, Alternate Delegate for 1951. Elected to the Board of Censors were Drs. Errett Pace, 1951-1953, Eugene Blake, 1951-1952, Bob C. Overby, 1951-1952.

Dr. Theodore Rosenberg presented his report on the Pittsburgh Plan. Motion was made by Dr. Eugene Blake, seconded by Dr. James A. Ward, and passed unanimously that the Society accept Dr. Rosenberg's report which is as follows:

"The Pittsburgh Blue Cross Plan, which is for Participating Employees of the United States Steel Corporation and Subsidiary Companies, arranged with the Community Hospital Service, Inc., or Blue Cross to honor their policies in Kentucky.

Among other benefits, they will receive those as furnished by Community Hospital Service, plus the following additional ones: (1) Anesthesia, only when administered by an employee of such hospital as a regular hospital service. (2) X-ray examination and electrocardiogram.

Since American Medicine has been, and is, engaged in a long time campaign to prevent the encroachment of socialized medicine into the realm of private practice of medicine and since American Medicine stands for free choice of doctors, there seems to be no reason to condone Corporate or Hospital practice of medicine, either. And certainly there should be no endorsement of a Voluntary Health Insurance Plan which specifically denies benefits for medical services, except when they are administered by a hospital employee, as a regular Hospital service; which in effect restricts free choice of doctors, and which in effect is another step towards domination of medicine by American Hospital Association.

Therefore, your committee makes the following recommendation: (1) That the McCracken County Medical Society go on record as, first, opposed to any Hospital Insurance Plan which in its contract provides services ordinarily administered by physicians, and



secondly, to endorse only those Health Insurance Plans which allow the free choice of the person who is to render service. (2) That the Councilor of the First District be apprised of the recommendation of the Society, and asked to present this to the Council for action at their next meeting."

The Board of Censors reported favorably on the application of Dr. J. M. Hunt. Motion was made by Dr. Eugene Blake, seconded by Dr. J. Vernon Pace, and passed unanimously that he be elected to membership.

The following bills were approved: Dr. Errett Pace \$10.50 (\$9.00 for Dr. Burford's hotel bill and \$1.50 for his dinner); Paducah Press \$3.00; \$50.00 for secretary payable to Peggy Hiatt.

Motion was made by Dr. E. W. Jackson, seconded by Dr. Eugene Blake, and passed unanimously that the County Society dues remain \$15.00 until changed.

Motion was made by Dr. J. E. Dunn, seconded by Dr. Eugene Blake, and passed unanimously that in the future all dues of members going to the Army have their local dues waived and the County Society pay their State dues.

Motion was made by Dr. Errett Pace, seconded by Dr. Eugene Blake, and passed unanimously to allow the Secretary \$50.00 per year until changed.

Motion was made by Dr. Eugene Blake, seconded by Dr. W. P. Hall that the new officers be authorized to decide at their discretion where to meet in January. Motion was defeated.

Motion was made, seconded, and passed unanimously that the officers meet with the management of the Ritz Hotel to discuss improving the meals.

Meeting was adjourned at 10:00 p. m.

Errett Pace, Secretary.

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### MUHLENBERG

The Muhlenberg County Medical Society met November 17, 1950. Members present were Drs. G. F. Brockman, R. E. Davis, J. H. Harrolson, B. B. Holt, George Richardson, G. H. Rodman, G. L. Simpson, J. P. Walton, Claude Wilson, Foster Wilson, H. H. Woodson, A. W. Andreasen.

The meeting was called to order by the President, Dr. H. H. Woodson. Minutes of the preceding meeting were read and approved. Dr. F. M. Wilson presented a paper on "Anesthesia for Emergency Surgery." This enjoyed a general discussion.

By unanimous approval, it was voted that an assessment of \$35.00 be made on all members, for the general purposes of the society.

On motion, it was adopted that the society have a representative at a meeting of the presidents of all local service groups and clubs to be arranged by the Women's Auxiliary for furthering the campaign for funds for hospital expansion. On motion the meeting was adjourned.

G. F. Brockman, Secretary.

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### MUHLENBERG

The Muhlenberg County Medical Society met December 1, 1950 with the following members present: Drs. G. F. Brockman, B. B. Holt, George Richardson, G. L. Simpson, J. P. Walton, C. Wilson, F. M. Wilson, H. H. Woodson, and A. W. Andreasen.

The meeting was called to order by the President, H. H. Woodson.

Minutes of the preceding meeting were read and approved. Considerable routine business was reported by the Secretary.

Dr. B. B. Holt presented a discussion of "Reticulo Endothelial Cysts," and other related subjects. Broad discussion followed.

On motion the meeting was adjourned.

G. F. Brockman, Secretary.

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### SHELBY-OLDHAM

Dr. W. P. McKee entertained the Shelby-Oldham Medical Society with dinner at the Stone Inn on Thursday, December 21, 1950.

The following members and guest were present, Drs. W. P. McKee and S. B. May, Eminence, H. H. Richeson, Hunt Jones, Louisville, H. T. Alexander, Crestwood, J. T. Walsh, LaGrange, H. B. Mack, Peewee Valley, B. B. Sleadd, Middletown and L. A. Wahle, M. D. Klein, A. D. Doak, W. H. Nash, A. C. Weakley, L. B. Sternberg and C. C. Risk, Shelbyville.

The following were elected for the coming year:

Drs. W. H. Nash, President, H. T. Alexander, Vice-President, C. C. Risk, Secretary-Treasurer, H. B. Mack, Delegate, L. A. Wahle, Alternate.

Dr. Hunt Jones, Louisville, gave a very interesting talk on Biblical Characters pertaining to medicine.

The next meeting will be on Thursday, January 25, 1951.

C. C. Risk, Secretary.

## News Items



**G. L. SIMPSON, M. D.**  
**Greenville**

Dr. Simpson has served in the following capacities in our organization:

President of the Muhlenberg County Medical Society

Councilor of the 2nd District

Member of Kentucky State Department of Health

Vice-President Kentucky State Medical Association, 1936

Served on Medical Economics Committee, and at present as Chairman

Delegate to State Medical Association

Capacities in other organizations:

Member of the Executive Committee, Southeastern Surgical Association

Fellow of the American College of Surgeons

Dr. J. Raymond Aker, Somerset, a physician and surgeon in Knott and Floyd counties for the past eleven years has returned to Somerset. A graduate of Science Hill High School, Dr. Aker attended Centre College, taught school in Pulaski county for twelve years and was graduated from the University of Tennessee Medical School in 1935. For the past four years Dr. Aker and son, Dr. Charles M. Aker, have owned and operated the Stumbo Memorial Hospital at Lackey. Dr. Charles Aker took his premedical work at Lincoln Memorial University and the University of Kentucky and was graduated from the University of Tennessee Medical School in 1945. He will remain at Lackey in charge of the Stumbo Hospital.

At the meeting of the Southern Medical Association in St. Louis, November 16, 1950, Dr. Robert Lich, Jr., was elected Chairman for the Urological Section. The 1951 meeting will be held in Dallas, Texas.

Dr. Lich's professional associations are as follows: Professor and Head of the Section on Urology, University of Louisville School of Medicine, Diplomate of the American Board of Urology, Fellow American College of Surgeons, Fellow American Medical Association, Member of the American Urological Association,

Member of the Southeastern Section of the American Urological Association, Member of the Southeastern Surgical Congress, Consultant Urologist, U. S. Army at Fort Knox, Nichols General Hospital, Home of the Incurables, Associate in Urology, Kosair General Children's Hospital, Chairman, Committee on Post-Graduate Education of the Southeastern Section of the American Urological Association, Executive Committeeman for Kentucky, Southeastern Section of the American Urological Association.

Dr. Lich has published over forty articles in various national organizations journals.

Dr. Robert M. Wooldridge has opened his office for the practice of general medicine in Hopkinsville and will be located in the offices of Dr. J. E. Stone, Cherokee Building.

During World War II Dr. Wooldridge served as an aviator in the U. S. Navy and served four years in the Pacific theatre of operations. After his discharge he studied medicine at the University of Louisville and graduated in 1949. He took his internship at Nashville General Hospital and at Vanderbilt Hospital and while there completed a course in anesthesia.

Eight Kentuckians have been approved for the Rural Medical Scholarship Fund and are as follows: Ollie B. Emerine, Vine Grove; L. C. McCloud, Jr., Jenkins, Proctor C. Rankin, Monticello; and Norman Keith Kirby, Burkesville, Robert R. Smither, Owenton; Jimmie Tulloh, Glasgow, David R. Upton, Monticello.

Vice-President Alben W. Barkley dedicated the new \$320,000 Clinton and Hickman County Hospital, December 28, 1950. Mr. and Mrs. Will L. Clayton of Houston, Texas, were the principal benefactors of the hospital. Mrs. Clayton was formerly from Hickman County and Mr. Clayton is one of the outstanding world leaders in cotton trading, and formerly U. S. Undersecretary of State.

Dr. E. M. Howard, Harlan, and Dr. George S. Coon, Louisville, have been re-appointed to the State Health Board by Governor Lawrence Wetherby.

Dr. D. P. Hall, Louisville, spoke before the Southern Section of the United States Chapter of the International College of Surgeons meeting January 11-13 at the Biltmore Hotel, Atlanta. Dr. Hall's subject was "Recurrent Inguinal Hernia."



**CHARLES YOHE, M. D.****Lakeland**

Dr. Charles Yohe, former staff psychiatrist at Essex county, Overbrook Hospital, Cedar Grove, New Jersey, has been appointed clinical director of Central State Hospital at Lakeland. He was graduated from the University of Nebraska College of Medicine in 1945 and served his internship at University Hospital, Omaha, Nebraska. Dr. Yohe has been well trained for his new post having studied psycho-analysis for several years with an instructor and training analyst of the New York Psycho-Analytic Institute.

Dr. C. J. Armstrong announces the association of Dr. John C. Weeter in the practice of Plastic and Reconstructive Surgery, Heyburn Building, Louisville.

Dr. B. F. Reynolds, Carlisle, has accepted the post of health officer for Nicholas and Bourbon counties. Dr. Reynolds has been a well known practicing physician in Carlisle for about forty years. One-third of his time will be given to Nicholas county and two-thirds to Bourbon county.

Delving into the past, I find that Dr. J. N. McCormack was secretary of the First National Conference of State Boards of Health from 1884 to 1885, and was president of this organization from 1886-1893.

In 1923 Dr. A. T. McCormack was president. The name has since been changed to Conference of State and Provincial Health Authorities of North America and at present Dr. Bruce Underwood, State Health Commissioner, is a member of the executive committee of this organization.

## *In Memoriam*

**OLIVER RUSSELL KIDD, M. D.****Paducah****1875 - 1950**

Dr. Oliver Russell Kidd, retired Paducah physician, died November 9, 1950. He was born in Livingston county in 1875 and was graduated from the University of Louisville Medical Department in 1898. He practiced in Carrsville until 1906, when he came to Paducah. He was a practicing physician in Paducah for forty-four years. Dr. Kidd was past president of the McCracken County Medical Society.

**M. D. SANFORD, M. D.****Sadieville****1869 - 1950**

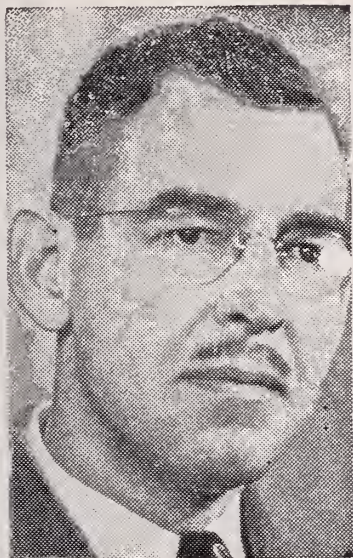
Dr. M. D. Sanford, aged 81, died November 19, 1950 after an illness of two years. He was born in Nicholas county June 9, 1869. He was graduated from the Kentucky School of Medicine, Louisville, in 1893 and had practiced medicine in Sadieville, Scott county, since graduation. He was a member of the Scott County Medical Society, and the Scott County Board of Health.

**FERDINAND L. KIEFFER, M. D.****Covington****1882 - 1950**

Dr. Ferdinand L. Kieffer, a practicing physician and surgeon for forty years in Covington, died November 6, 1950. He was born September 20, 1882. Dr. Kieffer was graduated from the University of Louisville Medical Department in 1904. He was a member of the Campbell-Kenton Medical Society and the Kentucky State Medical Association.

**DR. JOHN RYAN CLAYPOOL****Franklin****1862 - 1950**

Dr. John Ryan Claypool, a general practitioner in Simpson County for many years, died December 6, 1950. Dr. Claypool was born in Warren County, October 10, 1862, and was graduated from the Vanderbilt University School of Medicine in 1889, later studying at the New York Polyclinic School. He began his practice in Bowling Green and in 1896 moved to Middleton. He retired in 1941. Dr. Claypool was a former President of the Third District Medical Association.

**KENNETH C. REISING, M. D.**

Louisville

1907 - 1950

Dr. Kenneth C. Reising, a Louisville surgeon, died of a heart attack November 22, 1950. He had been practicing in Louisville since graduating from the University of Louisville School of Medicine in 1932. He was on the active staffs at Norton Memorial Infirmary, Kentucky Baptist Hospital, and St. Anthony's Hospital.

**JAMES ASHLAND TURNER, M. D.**

1873 - 1950

Dr. James Turner, former Ashland physician, died November 16, 1950. Dr. Turner was graduated from the Ohio State University School of Medicine in 1905, and began his practice in Ashland. After five years he moved to Borderland, West Virginia and in 1920 to La Pryor, Texas, where he practiced medicine until 1950 when he returned to his home in Summit, Boyd county, Kentucky.

**SAMUEL FULTON STEPHENSON, M. D.**

Albany

1876 - 1950

Dr. Samuel Fulton Stephenson, 74, for more than fifty-two years a practicing physician in Albany died November 22, 1950. Dr. Stephenson was graduated from the old Kentucky School of Medicine in Louisville in 1898. He served as a member and official of the Clinton County Board of Health and the Clinton County Medical Society most of the time since he began practice.

## BOOK REVIEWS

**ACUTE HEAD INJURY**, by Joseph P. Evans, M. D., Ph.D., Associate Professor of Surgery, Director, Division of Neurological Surgery, University of Cincinnati, College of Medicine, Cincinnati. 116 pages, with illustrations. Charles C. Thomas, Publisher, Springfield, Illinois. Price \$2.25.

Since the advent of rapid transportation, the general practitioner as well as the surgeon, should be aware of head injuries. Many times a supposedly drunk has been found dead the next morning in jail due to the lack of knowledge of cerebral symptoms, and with the continuous rise in automobile accidents, makes this one of the most acute subjects of the present day. With prospects of war for many years to come, this book written by a former member of the Armed forces, is a welcome guide to this type of surgery.

**PRACTICAL GYNECOLOGY**, by Walter J. Reich, M. D., F. A. C. S., F. I. C. S., Attending Gynecologist, Cook County Hospital, Professor of Gynecology, Cook County Graduate School of Medicine; Attending Gynecologist, Fantus Clinics of the Cook County Hospital; Assistant Professor of Gynecology, Chicago Medical School; Attending Gynecologist and Obstetrician, Grant Hospital; Attending Gynecologist, Fox River Tuberculosis Sanatorium; Consulting Gynecologist, Hazelcrest General Hospital. Mitchell J. Nechtow, M. D., Associate Attending Gynecologist, Cook County Hospital and the Fantus Gynecologic Clinic; Assistant Clinical Professor of Gynecology, Cook County Graduate School; Associate in Gynecology and Obstetrics, Chicago Medical School; Attending Gynecologist and Obstetrician, Norwegian American Hospital. With 187 illustrations, including 55 Subjects in Color. Publishers: J. B. Lippincott Company, Philadelphia. Price \$10.00.

Great progress has been made in the practice and methods of office gynecology, so that, today, many cases once thought to necessitate hospital care are now being treated as a part of ordinary office procedure.

This new book offers a simple, practical guide to the technics of office gynecology, including systematic routines of examination, laboratory tests, biopsy, cytology, diagnosis and management of commonly seen disorders. An extremely important feature is the fact that treatments and instruments recommended are those commonly available to physicians in general practice, and many useful improvisa-



tions are offered in gynecologic technics. Also, the book outlines procedures for the patient to follow as a supplement to treatment by the physician.

The contents of this book are based on years of out patient clinical work, and the many clear illustrations help to simplify the procedures and technics described in the text. It is a valuable reference book in the general practitioner's as well as the specialist's library.

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**CEREBRAL PALSY** by John F. Pohl, M. D., Orthopedic Surgeon, Michael Dowling School for Crippled Children, Minneapolis, Minnesota. Bruce Publishing Company, St. Paul, Minnesota. Price \$5.00. 1950.

No other problem in the medical field today is more in need of thoughtful attention than that of cerebral palsy. It occurs at birth and persists throughout the life of the patient.

It is estimated there are over 500,000 victims of all ages in this country and an estimate of 10,000 new cases occur every year.

It is one of the most serious causes of crippling in children.

The author sets forth the basic approach to treatment and outlines the methods of teaching the child to help himself. No better answer can be given to the efficacy of treatment than that of Dr. W. J. Little, pioneer orthopedist of London to whom is credited the first medical description of the disorder.

Dr. Little said, "I have had many cases under observation from one to twenty years and may mention as an encouragement to other practitioners that treatment based upon physiology and rational therapeutics effects an amelioration surprising to those who have not watched such cases. Many of the most helpless have been restored to considerable activity and enjoyment of life."

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**YOU AND YOUR HEART, a Clinic for Laymen on the Heart and Circulation** by H. M. Marvin, M. D. and T. Duckett Jones, M. D., Ivine H. Page, M. D., Irving S. Wright, M. D., David Rutstein, M. D. Foreword by Paul D. White, M. D., former President, The American Heart Association. Random House, Publishers, New York. Price: \$3.00.

Five of the nation's most eminent heart specialists have collaborated to combat with facts the panic which affects so many people at the mention of such terms as "coronary thrombosis," "arteriosclerosis," "high blood pressure," or "rheumatic fever." In simple, readable and authoritative words, the authors give the answers to questions about the heart and

its ailments. These answers, so far as medical science can supply them, cover the problems of the healthy and the sick where their hearts and blood vessels are concerned.

This truth about the various kinds of heart damage, what the chances are of getting them and what can be done about them are carefully annotated.

The book tells how much activity a man with heart disease can engage in, the amount will surprise most people, as well as the role of diet, drugs, exercise, rest, emotions. It tells how heart disease develops. Above all, it tells how the heart and blood vessels work in sickness and in health, a reassuring account that will help put an end to much needless mental suffering.

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**SAW-GE-MAH (Medicine Man)** by Louis J. Geriepy, M. D. Surgeon, Detroit; Senior Surgeon Mount Carmel Mercy Hospital, Detroit, four years Secretary of the United States Chapter of the International College of Surgeons. Publisher: Northland Press, St. Paul, Minnesota. Price \$3.00.

This novel is a story of Hal Adams, beginning with his boyhood in a tiny lumber town in upper Michigan, his dream of becoming a physician, his long and arduous years of medical study, and his unceasing efforts to be a successful practitioner. The title Saw-Ge-Mah is the Ottawa Indian tongue meaning Medicine Man.

Numerous books have been written about the various types of doctors, but none have discussed the practice of medicine with the thoroughness, the warmth and understanding as in this novel, and it should be a guide and inspiration to all medical students. It is also a fascinating story that will stir the hearts of its readers. The proceeds from the sale of this book goes to the Michigan Indian Foundation.

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**SEX WITHOUT FEAR** by S. A. Lewin, M. D. and John Gilmore, Ph. D. Foreword by Sarah K. Greenberg, M. D. S. A. Lewin, M. D. is the author of *Health and Hygiene* and was formerly Chief of the Bureau of Preventable Diseases, Boro of Richmond, N. Y. A former Field Director of Syphilis Detection Survey, a lecturer and a general practitioner for over forty years. John Gilmore, Ph.D., is the illustrator of *Sterility*, *Sex Endocrinology*, *Experimental Syphilis*, and many others. He was art director of the *Venereal Disease Exhibit* at the *Century of Progress Exposition*. The former art editor of *Clinical Symposia*, Sarah K. Greenberg.



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—Editorial: Dramamine,  
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RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**



**M. D., is the author of Facts and Frauds in Women's Hygiene. She is Associated Gynecologist and Obstetrician at the Jewish Hospital and the Kingston Avenue Hospital in Brooklyn, New York. Lear Publishers, Medical Division, New York. 1950. Price \$3.40.**

The sex function and reproduction are basic factors common to all people everywhere, yet a heavy veil of superstition and misinformation has been drawn for centuries over everything pertaining to sex, reproduction and marital relations in general.

The American people are trying to break through this veil and are tired of evasions and ignorance. There is a strong desire to learn the truth about sex and its place in our lives.. What makes the book valuable is its simplicity and clarity. It is easy for one to read and understand. In simple every day language, avoiding technical or obscure phraseology, the authors present medically, psychologically and ethically correct information on this subject. The book is not padded with extraneous material, but pursues one clear line. The illustrations are unique and vital.

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**PLASTIC AND RECONSTRUCTIVE SURGERY; A Manual of Management: By Farris Smith, M. D., F. A. C. S., Consultant in Plastic Surgery, Blodgett Memorial Hospital, Grand Rapids, Michigan. 895 pages with 592 figures. W. B. Saunders Company, Philadelphia and London, Publishers. 1950. Price \$15.00.**

It is the author's purpose to point out and emphasize that the teachings and trend of plastic surgery since World War I have been so influenced by the description and popularization of the tubed pedicle and its conveyed flaps, by the use of Indian forehead flaps in facial repair, by the popularization of the skin grafts of Thiersch, Reverdin and Wolfe, together with excellent mechanical methods of obtaining these, that many of the previous procedures have been forgotten or ignored.

The splendid illustrations provided in this book correct this and will serve as a guide to those who have not attained advantage of correcting cosmetic disability, as the few experts that America affords today. The author has presented the basic principles which are correct and methods of application which give the most satisfactory results. Accomplishment many of the results, that seem like a miracle from the illustrations, depends much upon the intelligent cooperation of the general practitioner who is concerned from the time of the initial visit until the patient is discharged. This book deals with many of the

congenital conditions whose successful reconstruction depends upon the skillful planning and management of the surgeon experienced in the design of flaps and grafts and scar construction. In many of these situations collaboration produces the desirable results.

The author, who has had more than thirty-five years of experience stated that this manual is mainly a guide and is not desired to stifle the initiative or limit the ingenuity of the surgeon. There are other methods that produce acceptable results, but they should be based on the principle outlined.

Even the general practitioner will enjoy viewing these illustrations and the almost unbelievable results described in this new edition.

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**REGIONAL ORTHOPEDIC SURGERY: By Paul C. Colonna, M. D., Professor of Orthopedic Surgery, University of Pennsylvania Medical School. 706 pages with 474 figures. Philadelphia and London: W. E. Saunders Company, 1950. Price \$11.50.**

This book has been mainly the outgrowth of teaching Orthopedic Surgery to graduate and undergraduate students from a regional approach. An attempt has been made to consider the common clinical conditions which are met with in the region involved, stressing the principles of physical diagnosis and treatment.

Practical discussions of the office diagnosis and treatment of such common orthopedic conditions as flat feet, strained back, bursitis, plantar warts, ingrown toenails, etc., are essentially appealing to the general practitioner.

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**A PRIMER FOR DIABETIC PATIENTS—An outline of treatment for Diabetes with Diet and Insulin including Directions and Charts for the Use of Physicians in Planning Diet Prescriptions: By Russell M. Wilder, M. D., Ph.D., F. A. C. P., Professor and Chief of the Department of Medicine of the Mayo Foundation, University of Minnesota; Senior Consultant in the Division of Medicine, Mayo Clinic. New, 9th Edition. 200 pages with 8 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price \$2.25.**

This book is designed to help the diabetics by placing in their hands a clear, non-technical, and authoritative guide for following out the doctor's instructions. The information in this book is not theoretical. It is absolutely practical, based on the experience of thousands of cases at the Mayo Clinic. It is, briefly, a handbook of things the patient should do and should not do. The author discusses insulin (including important protamine zinc in-



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sulin), what it is, the proper dosage, and how to administer it. It gives complete information on diet, including diet for children. There are sample menus, recipes and substitutes, and directions for the proper preparation of food. Food values are given as well as instructions for weighing foods. Tests for sugar and diacetic acid and two entire chapters on the complications of diabetes that include emergency diets, emergency insulin requirements, coma and its prevention and treatment, tuberculosis, child-bearing, nervous disorders, gangrene, care of the feet, etc. This "Primer for Diabetics," is a trustworthy "assistant" for the doctor, and indispensable advisor to the patients. It is a helpful book to the physician as well as the patient.

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**HOME NURSING TEXTBOOK.** Prepared under the Supervision of Nursing Services, American Red Cross. 91 illustrations; 235 pages; June 7, 1950. The Blakiston Company, Philadelphia 5, Pa. Paper Cover \$.60; Cloth \$1.00.

This is the sixth revision of the official Red Cross textbook on home nursing. It provides the necessary information to guide the homemaker in keeping the family in good health, assisting in case of illness, and supporting community action in the promotion of health.

Prepared primarily for those who take the Red Cross home nursing course, this book helps teach the following: How to Meet Simple Home Emergencies, How to Recognize Some Early Signs of Illness, How to Give Simple Home Nursing Care at Home, and How to Keep the Family Well.

The principles and practices are presented in a clear, readable manner, making this text a source of ready reference on home care of the sick and injured. Color line drawings, and photographs are used throughout to illustrate procedures and equipment. Selected additional references are included for those who wish to study further.

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**MEDICAL DIAGNOSIS, Applied Physical Diagnosis.** Edited by Roscoe L. Pullen, M. D., F. A. C. P., Professor of Graduate Medicine, Director of the Division of Graduate Medicine, and Vice Dean of the School of Medicine, Tulane University of Louisiana at New Orleans, Louisiana; Consultant to the Surgeon General, Department of the Army, Washington, D. C. Second Edition. With 601 figures, 49 in colors. W. B. Saunders Company, Publishers, Philadelphia. 1950. Price \$12.50.

Although there have been great advances made in therapy and laboratory facilities it is very difficult at times for the doctor to find out what is exactly wrong with the patient. With this in view the author has designed the New Second Edition to be a valuable aid to the general practitioner.

The author and his 23 eminent co-authors explain all the fine points of history taking, inspection, percussion, palpation, auscultation, endoscopy, X-ray, electrocardiography, etc.

While all modern laboratory diagnostic measures are included, the book emphasizes the fact that there is still no substitute for the considered evaluation of the whole patient by the physician and that the test tube does not make a diagnosis. Expert guidance is given on what to look for and how to evaluate findings, the physician is told how to set up a differential diagnostic pattern that will pinpoint his patient's disorder and with a minimum of time and effort. The author impresses the reader with the necessity of thoroughness, because more faulty diagnoses are from errors of omission than from errors of commission.

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**A TEXTBOOK OF GYNECOLOGY** by Arthur Hal Curtis, M. D., Emeritus Professor of the Department of Obstetrics and Gynecology, Northwestern University Medical School; and John William Huffman, M. D., Associate Professor of Obstetrics and Gynecology, Northwestern University Medical School; Attending Gynecologist, Passavant Memorial Hospital, Chicago. Sixth Edition with 466 illustrations, Chiefly by Tom Jones, Including 37 in Color. W. B. Saunders Company, Publishers. Philadelphia. 1950. Price \$10.00.

This new Sixth Edition gives a complete coverage of Gynecology which has been correlated through the long teaching and clinical experience of the author. All the recent advances have been incorporated by the senior author and Dr. Huffman. The chapters on Embryology and Urinary Tract Problems reflect extensive change, and there is much important new material on ovarian tumors, dysparunia, the para-urethral ducts, and other topics which have been added.

The section of Pelvic Anatomy, prepared in collaboration with Dr. Barry Anson and illustrated by Tom Jones, continues to be one of the finest presentations of this subject available. This standard textbook should be in the library not only of the specialist, but the general practitioner who usually sees the patients first.

# *The* JOURNAL *of the* Kentucky State Medical Association

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## GLOMERULAR NEPHRITIS

Leslie H. Winans, M. D.

ASHLAND

Broadly speaking, glomerular nephritis includes all renal diseases involving primarily the glomeruli of the kidney. We will limit our discussion to proliferative glomerular nephritis according to Bell's classification. Although the clinical entity has been recognized for a long period of time, the etiology and pathogenesis are still unsolved problems. In this discussion we will attempt to visualize the disease entity through the acute and chronic phases. With the clinical picture in mind, we will then attempt to discuss briefly the present etiological concepts and their application in the management of this problem.

When one realizes that the life expectancy of active chronic glomerular nephritis is about ten years, it makes one more aware of his responsibility. A large number of these patients will die in their early thirties. While acute glomerular nephritis may occur in any age group, it occurs most frequently in the first two decades of life. The incidence of chronic glomerular nephritis without history of the acute phase far exceeds those in which the acute phase was recognized as such. From this, it would seem that we are not recognizing the milder forms that later become active chronic cases. A child with rheumatic fever is always reason for concern on the part of the physician. The same concern and thoughtful consideration should be given the potential case of glomerular nephritis.

Like rheumatic fever, there are many cases of glomerular nephritis that are in a large sense, subclinical.

### Renal Anatomy and Physiology

If we are to visualize the changes which the glomeruli and the entire kidney undergo in this disease, we might first review the normal renal anatomy and physiology. The functioning unit of the kidney is the nephron. There are an estimated million such units in each kidney. Thirteen hundred cc. of blood circulate through the kidneys each minute. From this, one hundred twenty-five cc. per minute of filtrate are formed. This filtrate is composed of water, glucose, urea-creatinine, sodium, potassium, etc. These constituents are concentrated and reabsorbed by the tubules. Practically all the glucose, part of the urea, and sodium and potassium in proper proportion to maintain electrolytic equilibrium of the body fluids, are selectively reabsorbed. In the distal tubule the final concentration of filtrate takes place making possible ultimate conservation of body fluids. So in a healthy kidney we have a great deal of work being done. The blood is being cleared of noxious and excess elements. The body fluids are being maintained in proper physiologic balance.

### The Nephron

The nephron is an efficient and relatively simple anatomic unit. Its physiological activity is quite complex. A small arteriole enters the glomerular body and branches into several noncommunicating arterioles. These arterioles are very thin walled, the wall consisting of a single layer of endothelial cells. These arterioles finally lead into a common efferent arteriole. The efferent arteriole is somewhat smaller than the afferent vessel. The



blood enters this glomerular body in greater quantity and under greater pressure than it leaves. With these differences in pressure, the osmotic pressure of the fluid, and the pressure of the kidney substance itself, we have not only the physical basis for filtration, but also the physiologic requirements.

In acute glomerular nephritis it is this filtering unit that is primarily involved. The tubules may be secondarily involved. The proximal tubule is thought to maintain its functioning capacity. The distal tubule probably loses some of its ability to concentrate the urine.

### Pathologic Changes

In the very early stage of the process there is thought to be considerable spasm of the afferent arteriole with some swelling and engorgement of the endothelial cells in the glomeruli themselves. This results in a decrease in blood flow through the glomerulus with consequent lowered filtration rate. In addition, the swollen endothelial cells of the glomerular arterioles may permit the leakage of albumin and red blood cells. As the process continues, proliferation of the arteriolar endothelial cells takes place.

The lumens of these arterioles making up the filtering unit become plugged by the new cells and the influx of monocytes and polymorphonuclear cells. This particular form of reaction is spoken of as the intracapillary proliferative type of glomerular nephritis. A second type of reaction is sometimes noted where the endothelial proliferation occurs primarily in the parietal layer of Bowman's capsule. Here we have formed the so-called crescent bodies. As they increase in size, they compress the small glomerular arterioles until function is completely abolished. This form is spoken of as the extra capillary proliferative type. Both forms are frequently found in the same individual with one or the other type predominating.

The degree and location of proliferation and the number of glomeruli involved will determine the functional capacity of the kidney.

The acuteness of the onset, the rapidity of the progress of the reaction, and the degree of malfunction will vary within wide limits. We may have a very acute fulminating case or the reaction may be so mild that there is little evidence of its presence. It may be arrested with greater

or lesser renal insufficiency or it may continue into a chronic active phase. In addition, acute exacerbations may occur from time to time. The course of glomerular nephritis is entirely unpredictable.

### Classical Entity

The rather classical entity is familiar to us all. In it we have a patient who has convalesced from scarlet fever or some other streptococcal infection. After ten days to two weeks, he becomes less active, a bit irritable and he doesn't want to eat. Three or four days later he awakens with his eyes swollen shut and also finds that his feet are too big for his shoes. At this point the physician is probably called. He asks for a urinalysis, a blood count and perhaps some blood chemistries.

The urine is scanty and of a smoky color. It contains albumin and the sediment is full of red blood cells. Casts will be plentiful and they will contain red blood cells. The blood picture will show a mild anemia. The sedimentation rate will be increased and there will be urea retention.

Blood pressure readings should be taken. These may be normal in the beginning but will serve as a base line for later readings. In this type of case, the pressure usually arises and may be useful as a guide to progress. This is of particular value in evaluating recovery. Some men feel that a persistently elevated pressure during convalescence indicates the beginning of the active chronic phase. There may be cerebral signs manifested by headache, nausea, vomiting and papilledema.

Not all cases are classical however and the picture presented above may be quite different from what we see in a patient. As we reflect on the nature of the lesion, it is evident why this should be true. A reaction could be so mild that albumin and red blood cells could appear in the urine without any signs of renal insufficiency. There might be mild oliguria without evidence of peripheral edema.

### Urinary Findings

If spasm of the afferent and efferent arterioles is a prominent factor in the early phases of some of these cases, we might have hypertension and edema with little or no evidence of albumin or red blood cells in the urinary sediment. The urine findings depend on the vulnerability

of the arteriolar membrane. These sub-clinical cases will go unrecognized unless repeated post-infection urinalysis are performed. It is common practice to make a urinalysis during an active infection. However, in glomerular nephritis we know the disease does not develop until later in convalescence from the infection. Specimens at intervals during the three to four week post infection period will be of real value. This simple precaution may prevent an acute fulminating case of glomerular nephritis. We may uncover the subclinical case and be in a position to offer constructive management. It is these cases that are prone to become the active chronic cases of nephritis.

### Associated Conditions

The patient with glomerular nephritis may well have other problems that will tend to obscure the character of the malady. There may be a positive relationship between rheumatic fever and nephritis. They do sometimes occur in the same individual. More frequently associated with the condition is congestive failure. The heart muscle becomes involved as a result of the generalized disturbances in the cardio vascular-renal mechanism. Congestive failure manifests itself by decreased renal blood flow, oliguria, edema, albuminuria, and azotemia, symptoms common to both diseases. Super-impose this entity upon an acute glomerular nephritis and one has a critical problem requiring careful evaluation. The one very helpful differential point is increased venous pressure occurring in the case of congestive failure. In our discussion, we are primarily interested in pointing out this serious complication in order that we may be alert to its possibility. Cardiac, rather than renal, deaths are not uncommon in acute glomerular nephritis.

According to Hayman and Martin the acute attack of glomerular nephritis may terminate fatally in 5 to 10% of the cases, 10 to 20% will develop chronic glomerular nephritis; and 20 to 30% may enter the latent phase. This leaves 45 to 60% that will heal with a greater or lesser degree of impaired function. From these figures it would appear that about 40% of the acute cases may continue in a state of low grade activity. Some of these lesions will heal, others will progress gradually decreasing the functional capacity. Such kidneys appear to be particularly susceptible to intervening strep-

tococcal infections as well as other less specific types of infections.

### Clinical Picture

The clinical picture of active chronic glomerular nephritis may be divided into two groups. In the first group, we would place those cases showing signs of low grade activity but normal renal function. In the second group we would place those cases having evidence of activity and renal insufficiency.

#### First Group

In active chronic glomerular nephritis of group I there may be a few nephrons that have been completely destroyed, other nephrons that have been partially destroyed, and a few showing signs of mild pathologic activity. Therefore, in contrast to the acute phase, there will be less albuminuria, less hematuria, no oliguria, slight impairment of concentration powers, and little or no hypertension. The blood urea and creatinine will be normal. The sedimentation rate will be increased.

#### Second Group

However, as more and more nephrons are destroyed, renal insufficiency is inevitable and we evolve into the second group. These patients will be anemic, exhausted, and have varying degrees of renal insufficiency. The findings in the urinary sediment will be persistent but usually of lesser degree than in the acute phase. There will be a lower and perhaps fixed, specific gravity; albuminuria, red blood cells; and casts. Blood urea will be increased. There is prone to be a hypoproteinemia, and anemia may be severe. Hypertension is usually present. Oliguria and edema ensue. The edema may be a part of hypoproteinemia and congestive failure, rather than the oliguria. Death is usually a result of the uremia but may well be myocardial failure.

In our experience it is the active chronic group that has impressed us the most. These patients are usually in their teens or even younger. The history indicates that for a year or two there has been progressive evidence of fatigue, poor appetite, irritability, and stationary weight. We have not been able to establish a known initial infection in any great number of these cases. However, culture of the nose and throat gives a remarkable percentage of positive cultures of beta hemolytic streptococcus. We usually find



albumin and red blood cell casts in the urine. We have not seen marked elevation in pressure, but feel that, in the younger age group, systolic pressures persistently averaging around 125 to 135 mm of mercury probably indicate some hypertension. We usually do not see elevated ureas in this group, but there is nearly always a mild to severe anemia and a considerably elevated sedimentation rate.

### Difficulties Involved

Up to this point I have tried to present a practical picture of glomerular nephritis as we see it in our offices and in the hospitals day after day. We have tried to give a clinical picture of the patient having the disease in its various stages and to point out some means of recognizing and differentiating the disease. We have a great deal of positive knowledge which should enable us to recognize and to classify glomerular nephritis just as definitely as we recognize any specific entity. It is not an indefinite term to be loosely used for any kidney lesion or any proteinuria. The many things which we do not know or understand about glomerular nephritis should not discourage us to putting it down as an indefinite disease impossible to manage and recognize. We should be able to anticipate where and when glomerular nephritis may occur, to recognize its manifestations and to verify its existence by clinical and laboratory findings.

Here is a disease which has long been recognized and which occurs commonly, it may be tragic in its effects and deadly in its results, yet we have not found the cure nor even the cause for it. We have learned only to recognize and to manage enough to reduce its severity.

The things that we do not know about glomerular nephritis should make us far more careful to use the knowledge which we already have and to examine that which is being constantly collected by research workers in the field.

For there may be in that research some answer to why glomerular nephritis occurs, to what we may do to prevent it or to block it once the process is in progress. For this reason, we have felt it appropriate to review briefly a theory of etiology which is gaining widespread recognition and investigation. This is the theory that glomerular nephritis is a renal lesion which is initiated by an antigen antibody

response to an infection by the beta hemolytic streptococcus.

### Theory of Etiology

We know that glomerular nephritis is preceded by a streptococcus infection and that there is a time interval of 10-20 days between the primary streptococcal infection and the first appearance of clinical signs of acute glomerular nephritis. We know that the intensity of the renal lesion is maximal during the first few days of the disease. We know that there is no clinical evidence that a continuation of the streptococcal infection is necessary for the continuation of the disease. There is no evidence of streptococcal invasion of the kidney tissue itself; the pathological picture is rather one of a severe general involvement of glomerular tissue which is considered by some workers to be a part of a diffuse damage of the entire capillary network throughout the body. These facts lend themselves to the possibility that the disease is produced by an antigen-antibody reaction.

Since in glomerular nephritis this reaction involves mainly the kidney tissue, it was considered that we may have an antibody being formed to normal kidney tissue. A disease similar to glomerular nephritis has been produced in animals by the injection of a heterogeneous immune antikidney serum. The action of this antikidney serum in producing the disease could be blocked by an injection of kidney extract thus demonstrating the specificity of the serum for kidney tissue.

The next step after demonstrating that an antibody to kidney tissue could produce a glomerular nephritis, was to find the agent which would cause such an autoantibody to be formed. Here the knowledge of the preceding streptococcus infection was utilized, and experiments were carried out to find whether some product of the streptococcus might initiate the formation of a kidney antibody. It was found that in rabbits, antibodies to kidney can be produced by injecting a rabbit kidney extract previously incubated with streptococcus extract.

### Role of the Streptococcus

In order to investigate the role of the streptococcus in this immune relationship, titers for antibodies to the products of streptococci were determined. It was found that there was a higher anti-streptolysin titer in glomerular nephritis

than in normal patients or those with a recent streptococcus infection but no complications. It was felt that the presence of high antistreptolysin titers and their increase subsequent to reinfections seem to indicate that the streptolysin (or some similar product of the streptococcus organism) may be the factor which split up some otherwise non-antigenic kidney proteins and combined in a hapten-linkage with these proteins so that they became antigenic. The antibodies are not restricted to the hapten-linkage protein but attack normal kidney substance thus producing the allergic-type tissue reaction found in glomerular nephritis. Thus we would have the following factors coming into play to initiate our renal lesion of nephritis:

A streptococcus infection yields a streptococcal product which combines with kidney protein to form a linkage that will act as an antigen. This antigen will produce an antibody to the linkage that is not specific for the linkage, but will attack normal kidney tissue. The immune reaction between this autokidney antibody and the kidney tissue gives rise to the lesion of glomerular nephritis.

This theory has been supported by serological studies of antistreptolysin and streptococcal antihyaluronidase titers and of kidney autoantibodies in glomerular nephritis.

The streptococcus organism in an infection yields a toxin, streptolysin, and a specific enzyme, streptococcal hyaluronidase. These products, in turn, provoke antistreptolysin and streptococcal antihyaluronidase antibodies in the patient's serum. By making dilutions of sera and combining with indicator systems, the antistreptolysin and streptococcal antihyaluronidase titers can be determined. These titers have been found to be increased in glomerular nephritis.

The titer of antibodies to normal human kidney substance can also be determined by making dilutions of the patient's sera and combining with an indicator system using normal human kidney tissue as an antigen. These serological investigations showed the occurrence of antibodies to normal kidney tissue in patients having glomerular nephritis while normal control patients gave negative titers.

#### Antigen-Antibody Theory

The antigen-antibody theory suggests a new approach to prevention and treat-

ment of glomerular nephritis. Rammelkamp has found that adequate treatment of streptococcal infections by penicillin prevents the production of streptolysin and thus of the antibody antistreptolysin. Other groups have suggested the possibility of neutralizing the antikidney antibodies by means of kidney tissue emulsions or extracts. Also the use of antihistaminic drugs to mitigate the vascular effects of the immune reaction would bear investigation. Any measure which would depress the kidney antibody response should be helpful, if this theory is accepted.

In his book "Glomerular Nephritis," Addis makes the following statements, "Our ignorance of the conditions involved in the pathogenesis of glomerular nephritis is as singular as it is inexcusable. There is no other disease in which we have been given a better opportunity for the gathering of all sorts of information that might bear on this very practical question—and yet little has been done. There can be no rest for us as long as the prime reason for the tragedies that follow the initiation of glomerular nephritis may be nothing other than our apathy and indolence."

Because of this inadequacy of absolute information, and because of the far-reaching changes which the acceptance of the theory discussed would make in our handling of the disease, we have felt justified in digressing to present a theory of etiology in this a clinical paper.

#### Active Management

The active management of acute glomerular nephritis may well be divided into two parts, first, adequate management of streptococcal infections which will lessen the incidence of the active case. The second phase of management will consist of the management of the disease itself. As a prophylactic measure, active treatment of the streptococcus infection with penicillin or other antibiotic therapy will bring about a lower antibody response. Also duration of positive cultures of the primary infection will be shortened. Patients subject to frequent respiratory infections should be advised as to measures that might lessen their incidence. The question of tonsillectomy has been reviewed by Michel. The only help that may be expected from tonsillectomy is in elimination of the frequency of respiratory infections. Therefore he concludes



that the indications for tonsillectomy are based on the usual criteria.

The active management of a case of glomerular nephritis is directed towards eliminating the physiologic load of a kidney that has become incapacitated, and at the same time to maintain a physiologic equilibrium. The actual process of accomplishing this will no doubt vary somewhat with different practitioners. Certain general principles should be acceptable to all and it is these principles that we shall discuss very briefly.

### General Principles of Management

Bed rest is quite important. In bed rest one is able to maintain a uniform body temperature and in turn, a more efficient peripheral circulation. Rest also reduces metabolic activity which relieves the load upon the already decompensated kidney.

Absolute withdrawal of food and water for the first twenty-four to forty-eight hours will sometimes result in marked diuresis. In such cases, the initial edema is thought to be on the basis of a generalized arteriolar spasm which can be relaxed by starvation.

When diuresis does not ensue the starvation regime, the fluid intake to establish water equilibrium must be determined. Extrinsic loss of water may be determined by adding any urine that is voided to any fluid that may have been vomited or aspirated. Intrinsic loss of fluid, as may occur through perspiration and respiration in an average man, may be estimated at about 800 cc. per twenty-four hours. Fluid intake should then be adequate to cover this determined fluid loss. Daily weighings will serve as a guide as to whether water balance has been established.

For fluid intake, glucose solution is generally used. This may be given orally or intravenously. The glucose is used for its food value and protein conservation. A high glucose intake decreases protein mobilization and consequently decreases the metabolic by-products, particularly urea.

As a proper water balance must be maintained, so must the electrolytic balance be controlled. Normally one of the kidney's primary functions is to maintain acid-base equilibrium of the plasma. In nephritis this mechanism becomes greatly disturbed. With lowered filtration rate, there is likely to be complete absorption

of sodium. Sodium is then diverted from the plasma into the tissues in an attempt to maintain normal blood levels. Ammonia, which is normally formed in the tubules, becomes greatly decreased. This leaves no free alkaline element to neutralize the acids. As a result, fixed base is taken up and the alkaline reserve is decreased. With this decreased reserve, we have acidosis as a common sequella in uremia.

There is also a reciprocal relationship between plasma sodium concentrations and plasma potassium concentrations. When sodium decreases, the potassium factor increases. In elevated concentrations, potassium has a very toxic action on the myocardium, and may be a very potent factor in the production of myocardial failure.

In order to maintain normal plasma electrolytic balance, frequent observations must be made. When an imbalance is noted, this must be corrected. In case of decreasing alkaline reserve, it is wise to administer adequate amounts of bicarbonate solution. On the other hand it may be necessary to use normal saline solution. This would occur when considerable chloride was lost through vomiting or gastric aspiration. With such a changing electrolytic pattern, no specific rule can be formulated that will maintain normal balance. Each case is an individual problem.

### Convalescence

With convalescence, there may be more abrupt changes in the electrolytic balance. Don't feel that with diuresis your troubles are over. With large volumes of urine passing, there is likely to be a large quantity of sodium and chloride lost. If so, they must be judiciously replaced.

The edema in nephritis may be due to several factors. Low plasma protein and sodium retention are the more potent. Congestive failure may augment the edema but the same mechanism of pre-renal sodium deviation is at work. Sodium restriction is a very necessary step in the management. However, this cannot be an absolute rule. As previously pointed out, it may be necessary to administer sodium in some form to correct acidosis.

The plasma protein may be supplied by small transfusions of whole blood if there is anemia, or with plasma when this is the only element needing reinforcement.

### Use of Diuretic Drugs

The use of diuretic drugs in these cases has no value and probably does harm. Even the use of hypertonic glucose solution might be equivocal. However, with glucose, you are trying to furnish food and decrease protein metabolism so I personally feel that from a clinical point of view, it is justified.

Digitalis, when indicated, should be used to complete digitalization. As pointed out, myocardial failure is not uncommon and must be remembered. I believe there is a tendency to underdigitalize patients. Each patient will vary as to his required amount and no set formula for digitalization has yet been developed. Familiarize yourself with some good preparation and use it consistently. Knowing how to use a digitalis preparation is more important than what particular preparation is used.

### Specific Methods of Treatment

As to specific methods of treating the acute stages of glomerular nephritis with renal decompensation, I shall just mention two of the more common ones.

Theoretically, the only direct methods of removing retained products from the blood stream are by transperitoneal lavage or by the artificial kidney. Some cases have been treated successfully by such methods. The future of these methods will probably depend upon their simplification.

ACTH has also been used in acute glomerular nephritis. I am not in a position to discuss this treatment but believe it has been reported as being partially successful.

The management of the active chronic case of glomerular nephritis requires good cooperation of the family and the patient. Management extends over a considerable period of time, and the patient is not terribly ill. The family is probably concerned with the patient's irritability and listlessness. This part of the picture will greatly improve in the first three or four weeks of management. With this change there is likely to be laxness in the routine and the major problem may be neglected. So I think the first step in management of these cases is a complete understanding of the problem and the objective to be obtained.

### Management of Chronic Cases

In our experience, rest is invaluable. Without bed rest in the early part of this regime, we are unable to show any progress. Activity is gradually introduced as we feel it is indicated. After a brief period of activity we re-evaluate our patients and try to decide whether progress is being maintained and further activity is advisable.

Penicillin is used in the first two or three weeks of management. As previously noted, we have found a high percentage of positive beta hemolytic streptococcus cultures in these cases.

An attempt is made to lessen the frequency of respiratory infections. Should one develop, prompt treatment is advised. The anemia is usually easily corrected. Plasma protein is already of normal value.

The diet is designed with the idea of furnishing adequate food with the least possible load on the kidney. In addition we use a low sodium diet. Our best results have been observed in those patients that follow the dietary regime in an exact fashion.

We check these patients at periodic intervals of two to four weeks. This is important for two reasons. First, the patient needs encouragement. Secondly, the progress is being observed. Poor progress is often the result of poor home management.

### Urinalysis

All specimens of urine are collected under concentrating conditions. This is an important point. A urine with a specific gravity of 1.005 or less is not going to give many findings. In a concentrated specimen we are far more likely to pick up albumin and sediment findings, also we have some means of comparing findings from time to time, if specimens are collected under similar conditions.

### Terminal Phase

The management of the terminal phase of chronic glomerular nephritis is that of uremia. In addition one usually has the problem of a marked anemia and a failing myocardium. In these cases, it is a problem of prolonging life for a short period of time.

So for the present most of us are going to be forced to use our present knowledge of this disease entity. If we use this knowledge well, it is perfectly possible to



eliminate some of the cases, ameliorate others, and save lives in that group with more severe disturbances. In addition, I hope we will follow these patients for a time and make sure that an active chronic phase has not developed from the acute phase, or that it is receiving proper management.

(Bibliography furnished upon request.)

### DISCUSSION

**H. B. McWhorter**, Greenup: I have enjoyed Dr. Winans' paper very much. It leaves little room for further comment, therefore, I would like to limit my remarks to emphasize a point which I believe is of real importance. Dr. Winans made the statement that in the majority of cases of chronic glomerulonephritis, it is impossible to find a history of an earlier acute nephritis, so we may assume that in these cases the acute attack was so mild it escaped detection. It can be argued that these cases without a history of acute nephritis may never have had an acute phase, but have merged slowly into what we know as chronic glomerulonephritis. Bell, however, states that these cases show definite histological evidence of an earlier acute nephritis, as well as those chronic cases with histories of typical acute stage. When we remember that 1% of all

deaths over one year of age are due to glomerulonephritis, that for all practical purposes only the acute phase may result in complete recovery, and that almost 50% of the acute cases recover completely, we can see the need for finding more cases of glomerulonephritis while still in the acute stage.

We usually think of acute nephritis as following scarlet fever; however, Bell found only 1/3 of his cases of acute nephritis had occurred following scarlet fever or throat infections, while in the other 2/3, the antecedent infections varied all the way from impetigo to pneumonia. Many cases of acute nephritis with very mild symptoms or following other infections than scarlet fever are apparently being missed during the stage when proper care may determine the ultimate fate of the patient.

Let me urge the routine use of urinalysis following any infection from which the patient seems to recover slowly or when he still is not feeling perfectly well 4-5 weeks afterwards, regardless of how vague the symptoms are. In this way, if we are conscious of our responsibility and look for them, we will find cases of acute nephritis that otherwise would possibly have progressed unnoticed into the chronic form.

## A REVIEW OF CESAREAN SECTION IN A SMALL HOSPITAL

**S. H. Flowers, M. D., F. A. C. S.**

MIDDLESBORO

May I preface my remarks today with this quotation from Prof. Cornell, of Chicago: "The pregnant woman presents herself to her physician expecting to be delivered at term of a living baby and having the full right to demand that the delivery not leave her a cripple."

1533 such women have presented themselves to the members of the staff of the Middlesboro Hospital since its reorganization in January 1946. During that four and one half years up to July 1st, 1950 we have considered it necessary to do Cesarean Sections on 88 of these patients with the loss of only one mother, for a mortality rate of 1.13%. The incidence of Cesarean Section has been 5.7% of all cases delivered. There have been no fatalities in those cases delivered by the

natural route. We do not have neonatal or foetal mortality statistics available at the present time.

Ours is a privately owned hospital of 80 beds serving a city of 15,000 and the surrounding community. None of the doctors of our group do any home deliveries but the majority of babies born in our section are delivered at home. Of the cases referred to the hospital many are emergencies or are expected to become emergencies by their family physician. It is our goal in all of those cases in which we do the prenatal care to make any required Cesarean Section an elective operation. Both maternal and foetal mortality can be reduced thereby. More and more cases are being referred for possible section by physicians in the surrounding areas, indicating more careful prenatal care.

### Cesarean Section

A discussion of Cesarean Section as employed in any hospital revolves about the indications for which operative deliveries were done. Such indications have broadened during the past 10 years so that reference to a book or paper of earlier date shows a far lower number of sections but a tremendously higher mortality rate. For the city of Detroit the mortality rate was 13% in 1925 but in 1945 it was 0.8%. Comparable figures come from over the country justifying the increasing incidence of section. But we must not forget that at the same time vaginal delivery became much safer also.

a. Bleeding as a result of placental abnormality, whether abruptio placenta, placenta praevia or other, presents a situation demanding emergency action. We feel that Section is the choice. Eleven (11) of our cases were done for such bleeding.

b. Twenty-two operations were done for cephalopelvic disproportion. I include here those cases of funnel pelvis, generally contracted pelvis and deformity cases; also those cases not presenting any obvious disproportion but failing to respond to a reasonable test of labor. We do not subject women with definite disproportion to a test of labor but go ahead with elective section. You will note that a quarter of our cases come under this heading. So will many of yours and they will tax your judgment as they have ours.

c. Abnormal presentation appears only 3 times in this series, one a prolapsed cord, one an arm and one a transverse. You may say that a version would have been a better solution in some of these but we didn't feel so at the time. I am sure that a prolapsed cord calls for immediate operation.

d. Uterine Inertia, two cases failed to progress after long labors when there was no discoverable obstruction. We feel that watchfulness for postoperative bleeding is especially needed in such cases.

e. Fibroid Uterus will rarely be a cause of operative delivery today but we had two such cases in this series. One was a case in which a subserous fibroid had been removed during pregnancy in a 36 year old primipara, she then being delivered by section near her calculated term. The baby was normal in every respect and there were no complications.

f. Toxemia includes preeclampsias and hypertensive cases with, in most cases,

marked kidney damage, and accounted for 12 of our cases. For multipara induction of labor and conservative but energetic treatment of the toxemia is usually better than operation. However for primipara, especially those past 35 years, we do a section as soon as the patient goes into labor or the stage of probable viability is reached.

g. Nine of these 88 cases had had a previous cervical operation with scarring of the cervix which presented obstruction to delivery. Several of these patients had a severe cervical laceration at a previous delivery requiring anesthesia and high suturing to stop the hemorrhage. When one has successfully staunched such a hemorrhage he is not anxious to risk its recurrence by vaginal delivery of the same patient at a later pregnancy.

h. Epilepsy in the mother presents a problem since this is an inheritable disease. We believe sterilization is thoroughly justified. We had one such case in which section and sterilization was done.

i. Cardiac decompensation was present in four of our cases. We do not hold that all cardiac cases require section but try to decide whether the strain of labor would be more likely to produce decompensation than the operation proposed. We feel that most women with minor heart lesions can be and should be delivered normally.

j. Previous Cesarean Section was the reason for operating on 11 of the total of 88 women. All such cases should be elective and therefore carry a low risk. We recently had a prenatal case who had had six full term babies since undergoing a section for the first baby. Certainly no operation is needed in her case. Generally we adhere to the dictum "once a section—always a section." If the surgeon will look carefully at the uterine scar in a few of his own cases he will probably be a firm devotee of this dictum. If vaginal delivery is to be attempted next after a section it certainly should be in a hospital wherein emergency operations may be done on short notice.

k. The R-h factor and its meaning has come to be generally understood only since the beginning of this survey. Even a small hospital can equip its laboratory to do this test. We recently did a section two weeks before calculated term on a mother whose blood was R-h negative and in whom the titer was rising from week



to week. Mother and baby are doing well. I think this is the course to follow in these circumstances.

l. Generalized rheumatoid arthritis was the indication for one case and sterilization was carried out.

m. Venereal warts filling the vagina necessitated section in 3 cases. Such patients present a very friable vaginal mucosa which tears like wet paper. The risk of infection from vaginal delivery is increased in such cases but the probability of extensive tears, and hemorrhage from tissue which will not readily hold a suture, influenced us to do a section. One of these patients was a primipara of 39 years.

n. Cancer of the cervix was diagnosed in only one of our 88 cases and was immediately scheduled for section. We regard this as the only wise course to pursue when the diagnosis is made late in term and the operation is done as soon as the baby is viable. If the diagnosis is made early, pregnancy should be terminated, and the treatment appropriate to the case instituted with all vigor.

o. In three women varicosities of the vulva, vagina and legs was the indication for section and sterilization. This indication may seem strained to you and, looking back, I'll have to admit that it was in one of the three patients. Sterilization we cannot accept as a "per se" indication for an operation carrying definite risk to the patient. Many patients come seeking operative delivery and sterilization and must be sold on the fact that section is not the answer to their problem. Normal delivery and later operation is to be preferred unless there is some other reason for opening the peritoneal cavity.

p. Ruptured uterus is a rare emergency and the only such case I have seen in the 19 years since leaving medical school occurred in this series. This condition presents the only present day indication for the Porro type section. In our case the mother survived a ten mile ambulance trip to the hospital and is still living after 3 years. The baby was dead on arrival as is usually true in this condition. Energetic treatment for shock before, during and after operation is demanded in such a case.

### Technique of Operation

The operation generally employed in our clinic may be described as a low classical Cesarean Section.

a. Anesthesia: For the first two years covered by this report general anesthesia by gas, oxygen and ether was employed. During the past two and one half years spinal anesthesia has been used routinely. After this comparative experience we are convinced that the spinal is preferable. We are using a mixture of procaine and nupercaine but hold no particular brief for this combination. Pre-operative preparation is that required for good abdominal surgery.

b. The abdominal incision is low in the midline. In our experience the time required for opening and closing the abdomen is shorter. Proper closure will prevent likelihood of postoperative hernia. Furthermore this incision brings the surgeon down onto a lower segment of the uterus and into favorable position for the correction of any pathologic condition which may be present.

c. Following DeLee's advice ergotrate gr 1/320 is given intramuscularly at the time of making the skin incision. This gives a longer effect on the uterine musculature, reducing blood loss. Intra-uterine pituitrin is seldom needed.

d. While there is a great deal in the literature regarding extraperitoneal and low cervical sections I regard both as technically difficult and prefer, for the present at least, to leave them to the specialist. However, an incision made through the lower segment of the uterus and the upper cervical segment, after pushing the bladder down a little, is easy, avoids excessive bleeding and is much quicker of closure. The baby is then delivered, after rupturing the membranes, either as a breech or head first, according to its position in the uterus. In cephalic presentation pressure by the assistant on the fundus will facilitate the delivery and lessen the size of the incision necessary. The cord is cut and the baby passed to the nurse for any required resuscitation. With spinal anesthesia none is usually needed. The uterus is next brought through the abdominal incision and a tourniquet applied to shut off the uterine arteries. The uterine cavity is cleared of every vestige of placental attachment. Closure of the uterus is then carried out. We use (and strongly recommend) the atraumatic needles now available on the market and No. 1 chromic catgut. The peritoneal cavity is scrupulously cleared by suction or wet sponges and then closed without drains using No. 1 chromic to the

peritoneum and fascia and cotton to the subcutaneous tissue and skin. Stay sutures are not considered necessary.

f. Complicating pelvic pathology should be looked for and taken care of if it seems wise. Sterilization, when indicated, is done by excising a wedge of the cornu of the uterus with the isthmian end of the tube and then closing with figure of 8 sutures of No. 1 chromic. This is a positive procedure. It may be a temptation to remove the appendix while the pelvis is open but this generous impulse should be resisted in most cases.

Post-operative care is the same as for other pelvic operative cases with the added necessity of watching for uterine bleeding and breast disturbances. Early ambulation is definitely beneficial.

### Complications

(1) Dilatation of the stomach is more frequent than after most abdominal operations. Wangenstein suction is the treatment; use it early, combining, of course, intravenous fluids.

(2) Anemia responds to transfusions of whole blood. Iron and vitamin therapy with, or without liver extract, is reserved for later use or instituted immediately if considered necessary.

(3) Infection is avoided by routine use of the antibiotics and by careful technique.

(4) Postoperative bleeding has been very rare. Ice to the lower abdomen, ergotrate, pituitrin, and transfusion are used. We have not had to pack the vagina or uterus in any case.

(5) Peritonitis: In this series we have had one case of sepsis requiring drainage by opening the abdominal and uterine incision and placing a drain through the cervix into the vagina. The patient recovered rapidly after drainage was instituted.

(6) Early ambulation has helped us avoid phlebitis. When it has occurred in one or two cases Penicillin helped.

(7) Other complications arising are those of abdominal surgical cases and are similarly handled.

### Mortality

In this group of 88 cases we have had one maternal death for a percentage of 1.13. This occurred in a patient having vaginal bleeding near term and actually was an anesthetic death. Sufficient care was not taken to guard against shock following delivery and the patient died as she was being removed from the table after completion of the operation.

During the same period there has been no maternal mortality from vaginal delivery in 1445 cases, there having been a total of 1533 deliveries in our hospital in the four and one half years covered.

Foetal and neonatal mortality figures are not available in our series but since the emergency cases, bad risk cases, and bleeding cases have been the ones subjected to operation it is only natural that the death rate among these babies has been higher than in the general group. But if these same 88 women had been delivered per vagina by the various methods which are available I am certain both foetal and neonatal mortality would have been far greater, and probably the maternal death rate, too, would have been three or four times as great. Especially is this true in the 25% of our patients comprising the cephalopelvic disproportion group.

### Summary

A review of all the 88 Cesarean Sections done in the Middlesboro Hospital during the past four and one half years has been presented with a discussion of the operative technique used and the indications for which section was done.

### Conclusion

Our reasons for choosing Cesarean delivery, the technique used and the results obtained in our hospital have been presented. We feel that a well organized staff in any of the smaller and all the larger hospitals of the state should achieve comparable results and that a maternal mortality of approximately 1.0 to 1.5% can be obtained with a correspondingly low foetal mortality. We do not decry a reasonable rise in the incidence of Cesarean Section if the indications are sound and the mortality rate is kept down.



## TRACHEO-ESOPHAGEAL FISTULA IN THE NEW-BORN—SURGICAL REPAIR

J. Ray Bryant, M. D.

LOUISVILLE

Durston in 1670 described the congenital anomaly of esophageal atresia with tracheo-esophageal fistula. Sir G. Gray Turner estimated the malformation occurs about as frequently as hair lip and cleft palate. Haight, from the number of cases diagnosed in Washtenaw County, Michigan and the birth rate, estimated that the anomaly occurs once in about 22,000 live births.

### Embryology

The esophagus and trachea in early fetal life are one tube. Between the fourth and twelfth week of fetal life this tube becomes divided into two by an ingrowth of mesoderm. During this same period the lumen of the esophagus becomes obliterated by proliferation and concrescence of its epithelial lining. Later, this solid cord becomes vacuolated, the vacuoles coalesce, and the lumen is re-established in the same manner as in the intestine. An arrest in development, or failure of the mesoderm to completely separate the trachea from the esophagus, results in the tracheo-esophageal fistula, while failure of the vacuoles to coalesce results in atresia of the esophagus.

### Classification

Vogt's classification of this anomaly appears to be the most logical one.

TYPE I. Complete absence of esophagus.

TYPE II. Upper and lower segments end in blind pouches.

TYPE III. One or both segments communicate with trachea.

(a) Fistula between upper segment and trachea.

(b) Fistula between lower segment and trachea.

(c) Both segments communicate with trachea.

Ladd's classification which is more widely used is as follows:

TYPE I. Both esophageal segments end in 'blindly.

TYPE II. Upper segment communicates with trachea.

TYPE III. Lower segment communicates with posterior aspect of trachea.

TYPE IV. Lower segment communicates with trachea at the carina.

TYPE V. Both segments communicate with trachea.

### Clinical Findings

A newborn infant that has an excess of saliva or mucus in the mouth, the possibility of esophageal atresia should be considered. If all fluid offered by mouth is vomited and causes a paroxysm of cough with cyanosis, the diagnosis should be strongly suspected. A No. 8 or No. 10 French catheter should be introduced into the esophagus and an attempt made to advance it into the stomach. If an obstruction is met ten to twelve centimeters from the lips, the diagnosis of esophageal atresia is confirmed.

### Roentgenologic Examination

The type of anomaly present can often be determined pre-operatively with the aid of X-ray.

If air is present in the intestinal tract, the lower segment communicates with the trachea.

If no air is present in the intestinal tract, the lower segment does not communicate with the trachea or the fistula is quite small. No air in the intestinal tract means that the accomplishment of a primary anastomosis of the esophageal segments is less likely.

Next, iodized oil, never barium, should be introduced into the upper esophagus under fluoroscopic observation .5 cc. and never more than 1 cc. of oil should be used.

If the upper segment ends in a blind pouch, this will be outlined. This is the usual type of anomaly.

If the upper segment communicates with the trachea, iodized oil will be seen to pass from the upper esophageal segment into the trachea. Care must be taken

not to over-fill the upper segment allowing oil to be aspirated through the larynx.

### Pre-Operative Preparation

The diagnosis having been established, the infant should be placed in oxygen tent. A No. 8 French catheter may be inserted through the nose into the upper segment and constant suction applied. This prevents the upper blind pouch from filling with secretion which over-flows into the trachea and being aspirated. An alternative method is to place the infant in Trendelenburg prone position. This position allows the secretion to drain out the mouth. The pharynx should be aspirated every twenty minutes. The latter method has the advantage of stimulating the infant to cough frequently which helps to clear the tracheo-bronchial tree of gastric secretion entering through the fistulous communication with the lower esophageal segment. Turning of the infant from side to side helps promote bronchial drainage and to prevent atelectasis which is prone to occur early.

Penicillin is given in doses of 50,000 units every three hours. Sulfa and streptomycin may also be helpful.

Most infants are dehydrated when first seen, but special care must be taken to prevent over-hydration and edema. Five per cent glucose in water and plasma are given pre-operatively. Salt solution is not given. If the RBC is below 5.5 million, a transfusion of 10 ccs. of blood per pound body weight is given. A transfusion of this amount is given during operation.

Twenty-four hours is the maximum time to allow for hydration and treatment of pneumonia. It has been found that the infants are not improved by further delay in operation.

### Operation

There are three objectives in treating the usual type of esophageal atresia with tracheo-esophageal fistula. First, the fistulous communication between the lower esophageal segment and the trachea which allows gastric secretion to be regurgitated into the lungs must be divided. Second, the upper blind esophageal segment must be drained to prevent oral secretion from spilling over into the lungs. Third, a mode of feeding must be established.

Leven in 1939 first treated an infant with this anomaly successfully by first establishing a gastrostomy. After recovery, the fistulous communication between the

lower esophageal segment and trachea was ligated extrapleurally. At a third operation the upper blind pouch was exteriorized, forming a cervical esophagostomy. An ante thoracic skin tube esophagus was established in stages.

In 1941 Haight, using a posterior extrapleural approach, successfully ligated the tracheo-esophageal fistula and established the continuity of the esophagus by a direct end to end anastomosis. This has become the operation of choice and can be accomplished in a large majority of the usual type of anomaly.

In those instances in which it is not possible to bring the two esophageal segments together and in those in which the lower segment does not reach as far as the carina or is absent, the multiple stage procedure is still used. The jejunum has been successfully used both ante-thoracically and trans-thoracically to bridge the gap between the upper esophageal segment and stomach. The stomach has also been anastomosed directly to the upper esophageal segment both antethoracically and trans-thoracically with success.

Ether or cyclopropane administered through a face mask is the anesthetic of choice. Haight exposes the posterior mediastinum through an extra-pleural approach by resecting short para-vertebral segments of the third, fourth, and fifth ribs. Subperiosteal resection of the fourth rib on the right with exposure of the mediastinum via extra-pleural route is more easily accomplished, gives better exposure, and probably interferes less with chest motion in the post-operative period than does the multiple rib resection technique.

If the aortic arch is on the right side, a left sided approach is used. The azygos vein is divided. The vagus nerve is identified and traced inferiorly which leads one to the lower segment. This segment is excised from the trachea and the opening in the trachea closed with interrupted silk sutures. The upper segment is easily identified by having the anesthetist pass a catheter through the pharynx into the upper esophageal segment. The upper and lower segments are then approximated with interrupted sutures of 5-0 silk. A small rubber dam drain is placed near the anastomosis and brought out on the back. A catheter may or may not be placed through the anastomosis into the stomach. A gastrostomy is usually performed twenty-four hours after the first operation, us-



ing local anesthesia. Glucose water is given by gastrostomy after eight hours and formula in twenty-four hours. Feeding by mouth is begun on the tenth or twelfth day if there has been no leak of the anastomosis.

Six infants with tracheo-esophageal fistulas have been successfully treated to date. Five had the usual type of anomaly, that is, a blind upper esophageal segment with the lower esophageal segment communicating with the trachea. One infant had a fistulous communication between the esophagus and trachea in the lower cervical region without atresia of the esophagus. This fistula was divided by a thoracic approach.

In summary, any new-born who has an excess of mucus and who chokes, vomits, or becomes cyanotic when feeding is attempted should be suspected of having an anomaly of the esophagus. Failure of a small catheter to pass into stomach confirms the diagnosis. Early diagnosis and prompt surgical attention will save the life of many infants with this malformation.

#### Case Report

Patient was admitted to Children's Hospital on April 4, 1949 at 5:30 a.m. in a serious condition. The three day old infant was admitted because of vomiting everything offered him within five minutes. He was started on breast. The infant turned

blue on most occasions after attempted feeding.

Patient was dehydrated. Fever was 104°. An attempt to pass a catheter into the stomach was unsuccessful. Lipiodol was instilled into the upper esophagus, demonstrating blind pouch.

Air was present in intestinal tract.

75 ccs. 5% glucose in water, given intravenously, 120 ccs. 5% glucose in water, given subcutaneously. Vitamin K, 100 mg., subcutaneously. Penicillin 50,000 units stat and every three hours. Ankle vein started. Temperature dropped to 99° by 9:00 a.m. The patient was operated upon at 7:00 p.m., day of admission. The fistula was divided and closed. A primary end to end anastomosis of the esophageal segments was accomplished.

The tube left through anastomosis was removed on the fourth post-operative day.

Feeding by mouth was begun on the fifth post-operative day.

Twenty-sixth post-operative day, difficulty developed in taking formula by mouth. Oral dilatation, using filiform and follower, No. 12 and No. 14, was used. Forty-seventh post-operative day, gastrostomy was performed under local anesthesia and string was passed. Retrograde dilatations at weekly intervals were begun.

This baby is now over eighteen months old, eats a normal diet for his age, and is healthy in every respect.

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## CUTANEOUS BLASTOMYCOSIS

Ralph L. Cash, M. D.

PRINCETON

Thirty-eight fatalities from fungus disease are recorded in the vital statistics of Kentucky for the ten-year period, 1939 to 1948, inclusive. Actinomycosis, moniliasis, sporotrichosis, histoplasmosis, and blastomycosis are included among the recorded fatalities. Six deaths were due to blastomycosis (1).

Blastomycosis is a chronic, infectious disease produced by budding, yeast-like organisms grouped as blastomycetes (2). It has been stated that its prevalence in Kentucky is more common than might be expected ordinarily (3).

Clinically, cases of blastomycosis fall into one of two groups: the cutaneous, in

which the lesions are confined to the skin; and the systemic, in which the internal organs, most often the lungs, are involved (4). It should be noted, however, that the systemic cases usually show some secondary skin manifestations; and that, while the cutaneous form usually does not spread to the regional lymph nodes or to the blood stream, it may on rare occasion do so (2), (5).

The cutaneous form is curable, although its course may extend for several years. The systemic form is fatal in 90% of the cases within three years of the onset of symptoms, although the prognosis may be improved by early recognition and prompt treatment (6).

### History

The usual history of cutaneous blastomycosis is that there appears on some exposed part of the body, most often the face or neck, a single papule, pustule, or abscess, which ulcerates and exudes pus that dries and forms a crust. The lesion progresses slowly by marginal extension and may attain a diameter of several inches. Unless there is secondary infection, there is an absence of general toxic disturbances attributable to the local disease.

### Physical Examination

The clinical appearance varies with the size and age of the lesion, but the three following characteristics generally are found:

1. A border, which is elevated, band-like, serpiginous, and violaceous or dusky-red in color. This border slopes abruptly to the normal skin and contains many, pin-point-sized, miliary abscesses.

2. A surface, which, upon removal of the crust, shows wart-like papilliform elevations and crypts, in which are miliary abscesses that exude a mucilaginous, mucopurulent fluid.

3. A scar, which is soft, supple, white, and non-contractile. This healing process begins generally in the center of the lesion (7).

The commonly accepted characteristics of cutaneous blastomycosis are in summary: A crusted, wart-like lesion, which bleeds easily and has a definite, raised border, honeycombed with minute abscesses containing thick, glary, or mucoid pus (6).

### Laboratory Diagnosis

Smear, culture, biopsy, a tuberculin-like skin test, and a complement-fixation reaction are utilized in establishing the diagnosis. The diagnosis is certain when the *Blastomyces Dermatitidis* is obtained in a culture from the lesion. A presumptive diagnosis may be made when the organisms are present in the exudate or ex-cised tissue.

Examination of the pus is easily done. The pus may be examined pure (8), or it may be mixed with a drop or two of tap water (9). With the high dry lens, the organisms appear as round or oval bodies, about one to three times the size of a red blood cell (10). They have a doubly-contoured, highly refractile membrane and may show budding.

### Treatment

The oral administration of a saturated solution of potassium iodide is accepted as the most reliable method of therapy in blastomycosis. It produces marked improvement in the majority of cases; however, in many instances the improvement is only temporary. At times it even has an adverse effect and hastens the spread of the infectious process. Good results, however, are obtained consistently, when iodide therapy is supplemented by the judicious use of X-ray, desensitization with vaccine, and suitable surgical procedures.

The adverse effect of iodides may be anticipated from the response of the patient to a skin test with a standardized blastomyces vaccine. It is recommended that this test be performed before any course of therapy is started (6).

If the tuberculin-like skin reaction is negative or weakly positive, rapidly increasing doses of iodides may be given without fear of accelerating the spread of the disease.

If the skin reaction is strongly positive, the individual is considered to be hypersensitive or allergic to the infecting fungus. Iodides may be distinctly harmful if the patient is allergic.

In the treatment of the latter type of patient, therapy should be begun by desensitization with injections of gradually increasing amounts of blastomyces vaccine. The dose is kept below the point of causing a local or general reaction. Complete desensitization is not to be expected and is not thought necessary. If, however, the skin test is repeated after desensitization, the reaction will be found to have reduced markedly.

After two to four weeks of vaccine therapy, the degree of allergy has usually been reduced, as judged by skin testing, to permit the cautious administration of iodides. If there should be an exacerbation of symptoms, the drug should be discontinued promptly, and desensitization therapy should be resumed.

Blastomyces vaccine should be given until iodides are tolerated without unfavorable reaction. Beyond this, the repeated administration of vaccine may be prescribed according to the judgment of the physician.

The saturated solution of potassium iodide is usually administered with an initial dose of three drops three times



daily. This is increased one drop each dose each day until tolerance is reached. Although doses up to 150 grains three times daily do not usually produce iodism (11), many patients cannot tolerate this dosage.

Sodium iodide, intravenously, in a dosage of 15 to 30 grains, may be given to supplement oral therapy. A dosage as high as 60 grains intravenously has been employed (12).

Local medications have proved of little value, although many have been employed. Those which have been used most consistently are tincture of iodine (13), (14) and phenol (15).

X-ray therapy is an important aid in treating cutaneous lesions and has been combined successfully with other therapeutic procedures. X-ray alone has been adequate in the treatment of small and early lesions (16), (17), but the results are inconstant in larger and older infections (18). 75 to 100 roentgen units, filtered through 1 mm. of aluminum, are given at weekly intervals, with a total dosage not to exceed 1200 to 1500 roentgen units (10). The lesions may become radio-resistant (19), and it has been reported that good results may be obtained by two or three larger, destructive applications of X-ray (20), or an erythema dose, repeated after seven weeks if necessary (21).

Surgical procedures are of value in many instances, particularly when the lesion is small and lends itself to total excision (22). Destruction of the granulating tissue by cauterization, electrocoagulation, or curettage has been combined with iodides and X-ray successfully in a large number of cases. Aspiration of abscesses, except for purposes of diagnosis, and incision and drainage should be deferred until medical treatment has been initiated (23).

### Case Report

The following is a typical case of cutaneous blastomycosis: The patient is a white, male farmer, 58 years of age, who presented himself for examination in January 1948. His illness had begun two and one-half years previously when he had noted the development of a nodule at the inner base of the right anterior triangle of the neck. This nodule developed rather rapidly, enlarged to about the size of a hen egg, and became soft and fluctuant, but did not become sore or discolored.

One month of treatment with poultices and salves did not affect the appearance of the swelling, which was then incised and drained of pus.

Following this, the skin around the incision became involved with a "yellow slime and a thick scab, surrounding which was a raised ridge." Various local applications and a course of penicillin had no influence upon the progress of the disease.

About one year after the onset, treatment with superficial X-ray therapy was begun and for the next year and a half this was continued every two weeks. With this treatment there was healing in the center of the lesion and a disappearance of the elevated border around a considerable portion of the involved area. Progression continued, however, wherever the raised border remained.

About a year and a half after the onset, a second abscess developed on the back overlying the right scapula. This was incised and drained and went through the sequence of events described above but did not enlarge and remained rather stationary without further treatment.

Examination revealed a dusky-red ridge, elevated about three-eighths of an inch, that extended across the upper anterior neck from just beneath the mastoid process on the left to just below the angle of the mandible on the right. In this border there were many miliary abscesses from which drops of pus could be expressed. Below this ridge there was a soft white scar, with atrophy of the skin, and with scattered areas of brownish pigmentation, which gave to the whole an appearance suggestive of parchment paper. This healed area covered the entire front of the neck, extending laterally onto the supraclavicular areas, and onto the chest as far as the sterno-manubrial joint. The other lesion, on the back, was flat, with a dry verrucous surface from which purulent material could be obtained only with difficulty. It measured about two inches in diameter.

The patient presented no other abnormalities. The Kahn test, a complete blood count and differential, the urine examination, and an X-ray of the heart and lungs did not reveal any pathological findings.

Specimens of the pus obtained from the lesions were sent to Dr. E. S. Greenwood Waters, Louisville, who reported the presence of *Blastomyces Dermatitidis*.

both in the smears of the pus and in the cultures of the pus.

Blood was sent to Dr. N. F. Conant, Duke University, for examination of the complement-fixation reaction, which was positive, undiluted, and doubtful, when diluted 1:2. Other dilutions were negative.

A skin test was performed with blastomyces antigen, obtained from Dr. Conant, and showed an erythema, measuring 1.3 cm. in twenty-four hours, that had faded in forty-eight hours to leave a small skin nodule. Although the skin test did not indicate hypersensitivity, blastomyces vaccine was administered for one month, concomitantly with oral potassium iodide.

The maximum dose of oral iodides attained was 200 grains of potassium iodide daily. This was reached during the fourth month of treatment, was continued at this dosage for about two months, and then very slowly and gradually was reduced. Daily intravenous injections of 31 grains of sodium iodide were given during the third month. Iodides were administered contin-

uously for eleven months, and intermittently for another seven. No symptoms of iodism ever appeared.

The response to treatment was most gratifying. There was a prompt disappearance of pus, and the ridge receded, until at the end of six months there remained only papillary projections which had somewhat the appearance of tiny mushrooms. These were treated with several applications of bichloroacetic acid, following which they dropped off. The lesion on the back healed concomitantly with that on the neck. No local medicaments, or dressings, were ever employed. During the year following the cessation of iodides, there has been no recurrence.

### Summary

Gilchrist in 1894 first described blastomycosis in America, and the disease has been referred to frequently as "Gilchrist's Disease." The cutaneous form produces a chronic, granulomatous lesion sometimes persisting for many years. Because of their chronicity, the lesions in the skin are to be differentiated from other cutaneous granulomas and from skin neoplasms. A combination of iodides and x-ray, supplemented by vaccine therapy and suitable surgical procedures, will usually effect a cure. Even one instance has been reported in which a change of climate may have played a part in effecting a cure (24). Recurrences, however, are not uncommon (21). Treatment may need to be continued for months, or, in some instances, for even years.

Attention is called to the ease with which pus from this disease may be examined. It is not necessary to heat, fix, or stain the material. A drop of pus may be covered with a cover-glass and examined with the high, dry lens of the microscope. The yeast-like blastomycetes are generally visible very readily (25). Essentially the same statements may be applied to the diagnosis of another of the fatal fungus diseases in Kentucky; namely, actinomycosis.

A great deal of emphasis has been placed in recent years upon the necessity for biopsy in the diagnosis of any skin lesion which does not heal within a relatively short period of time. Your consideration is directed to another, much simpler procedure which may be performed in the offices of every general practitioner; namely, the examination of a wet smear from the discharges of any chronic lesion. Ma-



Fig. 1—Appearance of patient, January 1948, just before beginning treatment with iodides.



Fig. 2—Appearance of patient one year after discontinuation of treatment.



terial for culture and for more detailed examinations may be sent to a laboratory.

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#### DISCUSSION

**Robert L. Kelly, Louisville:** As you know, it is not the privilege nor the obligation of a discussant to criticize his colleague's paper. Rather, it is his duty to agree or disagree with the statements therein, and to attempt to substantiate his own opinions. However, I believe that in this particular case, a little constructive criticism is not out of line. This dis-

course on Blastomycosis is outstanding for its clarity of statement and for its straight forward presentation of a difficult subject. Dr. Cash's grasp of essentials and his thorough knowledge of subject should put many of us dermatologists to shame. I thoroughly agree with my colleague on most counts, but I believe there are a few points which could be clarified.

As stated, Blastomycosis may be divided clinically into two classes, the cutaneous and the systemic. Most of the localized infections do not endanger life and respond fairly promptly to adequate treatment. The systemic type is necessarily always dangerous. One point which Dr. Cash did not bring out too forcibly, is that with the cutaneous type there is always present the danger of systemic dissemination. I have seen and treated numerous cases of cutaneous Blastomycosis, and at least two cases of the systemic type. In both instances the systemic cases have been preceded by cutaneous manifestation.

This condition is far more prevalent in men than in women, and fifty percent of the cases occur after the age of forty. As far as the cases I have seen personally are concerned, I would say that Blastomycosis in women is a rarity. Another interesting fact to me is that this condition is more prevalent among farmers than among any other single group of workers.

It would seem that we are living in the Golden Age of dermatological therapy. So very often, in recent years, we have been presented with new "wonder drugs" such as the Sulfa drugs, Penicillin, Streptomycin, and Aureomycin. It is perhaps difficult to realize that these outstanding drugs, which have such a wide variety of usages, have failed to aid in the treatment of Blastomycosis. It would seem that no drug can take the place of Potassium Iodide for this disease. In my opinion, this drug is a prime factor in treatment, but to say that "X-ray therapy is an important aid in treating cutaneous lesions" is something of an understatement. Potassium Iodide medication and X-ray therapy are complementary factors. I say this because I have seen several cases where X-ray therapy alone has caused complete involution of lesions. On the other hand, I have seen cases where X-ray therapy was necessarily withheld for one reason or another, and the lesions involuted beautifully under Potassium Iodide medication alone. X-ray, used in conjunction with this drug, is the treatment of choice and often produces spectacular involution as to time and cosmetic result. However, I have also seen cases where a combination of X-ray therapy and potassium iodide medication has failed

utterly. Before the advent of the desensitizing vaccine, the importance of potassium iodide was demonstrated dramatically when a Blastomycosis patient was intolerant to the drug and other measures had to be substituted. The time period for involution was definitely lengthened. Dr. Cash has gone into considerable detail regarding this vaccine and the dosage of both it and potassium iodide, and I heartily agree with him. In regard to X-ray therapy, I have found that an erythema dose is usually more effective, in the treatment of this disorder, rather than the smaller, more frequent doses.

I need not point out to you, I am sure that here we must give grave consideration to the site of the lesions, the age of the patient, and the amount of congestion present in the skin. We must also take into consideration possible lack of cooperation on the part of the patient at home, which can so easily result in embarrassment for both the patient and the physician. Needless to say, it is always wise to have a complete blood count made before instituting treatment.

Dr. Cash mentions the value of surgical procedures. In some cases, where we have only one or two, small, superficial lesions, of short duration, this is the treatment of choice combined with Potassium Iodide medication. It is definitely the treatment of choice where a history of previous X-ray therapy is given. Caution or fulguration is, in my opinion, the most effective surgical method, and usually gives a fairly good cosmetic result if the patient will cooperate at home regarding cleanliness.

It has been reported that healing can take place spontaneously but it has not been my good fortune to witness this. These cases, which involute spontaneously, must be few and far between. Blastomycosis is considered to be one of the more serious problems in Dermatology and, unfortunately, we have no specific treatment for this rather common disorder.

**E. S. Greenwood Waters, Louisville:** I appreciate the privilege of being able to discuss Dr. Cash's well prepared and excellent paper. The paper is so complete it leaves little to add except from the laboratory point of view. Though the definitive diagnosis rests in the laboratory, the responsibility of case finding and suspecting this disease rests with the clinician.

Cutaneous blastomycosis is a slowly progressive disease and when the lesion is sufficiently advanced to the textbook picture stage of miliary abscesses and typical central parchment scarring even a lay person would not fail. However the earliest lesion appears as a

small granulation. At this stage the dermatologist may well send the lesion to the laboratory as a biopsy. At this stage, too, the laboratory diagnosis may not be evident. Organisms may be few or may not show typical budding forms. In a slide preparation budding may be induced by allowing the slide to stand at room temperature over night after ringing with vaseline or oil.

From the histologic point of view pitfalls for the pathologist to avoid are several. Marked epithelial hyperplasia at the margins of ulceration may suggest cancer. Intraepithelial as well as superficial miliary abscesses may suggest bromoderma. Again, if the typical forms of budding yeast cells with double refractile capsule are missing, other granulomas, with giant cells, macrophages, fibroblasts and neutrophils, must be ruled out.

The diagnosis from culture is simple provided one is thoroughly versed in the subject. In mycology the average laboratory technician is not too competent. The distinguishing characteristic of the Blastomycetes Dermatiditis is that at room temperature, grown on Sabaroud's glucose agar, the organism acts as a fungus. That is it produces a white cottony colony which with time turns to a tan and finally a brown color. While in cultures grown at 37° on blood agar or on beef infusion glucose agar, the organism retains its yeast-like growth. That is as it grows in the body with budding forms. (If the latter two media, the blood agar and the beef infusion glucose agar, are kept at room temperature we get a waxy, wrinkled growth with budding forms and a few abortive mycelial forms.) In the fungus type growth the mycelia, at first, are short, broad, thick walled and closely septate. They then change to long forms with oval to round conidia 3 to 4 micra in diameter attached to the hyphae near the septations. There may also be oval to pyriform conidia 4 to 5 micra which are borne on lateral sterigmata of varying lengths. Clamydospores 7 to 8 micra with thick outer walls are found in still older cultures.

From the cultured standpoint we must consider in differential diagnosis Blastomyces Brasiliensis Cryptococcus neoformans or European Blastomycosis and Coccidioides Immitis. Blastomyces Brasiliensis has spores which exhibit multiple budding. The colonies are also smaller, slower growing and in the mold-like phase have less extensive aerial mycelia and few conidia. The Cryptococcus Neoformans is always yeast-like, never fungus-like. Coccidioides Immitis shows endosporulation and the organisms are larger, 20 to 80 micra as compared to 15 to 20 for Blastomyces Dermatiditis.



Animal inoculation is indicated if no organisms are found in smears or in tissue sections. Either mice or guinea pigs are injected intraperitoneally. In 3 weeks they develop abscesses in the liver, spleen, lungs and lymph nodes. In the abscesses are found the typical budding yeast forms.

The complement fixation test is most useful in the systemic type. It may be negative in the cutaneous form. If positive in this type of disease it is positive only in undiluted serum or in very low dilutions, as it was in Dr. Cash's case. This is so in spite of the fact that the organisms of the systemic and cutaneous forms are identical.

I do not believe Dr. Cash mentioned the epidemiology. The disease does not appear to be infectious, but may be transferred by direct inoculation from person to person. Man usually presumably gets his infection from soil, with animal hosts as one source of infection and reinfection.

To sum up briefly: the diagnosis of cutaneous blastomycosis may be easy, but in early or obscured cases organisms may be few and resort to biopsy, culture and animal inoculation may be needed. The definitive identification of the organism is by culture which requires special care and knowledge.

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## HOMOLOGUS SERUM JAUNDICE TREATED SUCCESSFULLY WITH AUREOMYCIN

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OUTWOOD

The treatment of infectious hepatitis and homologous serum jaundice has been well established, consisting in more or less prolonged bed rest depending on the persistence of symptoms and high carbohydrate, high protein and low fat diet. Additional therapy consists in administration of lipotropic agents, vitamins and liver extract. Although aureomycin has been used successfully in diseases of virus etiology, i. e., virus pneumonia and herpes zoster, no instance of its use has come to the writer's attention in cases of virus hepatitis. On this account, a report is given of a case diagnosed as homologous serum jaundice in which administration of aureomycin appeared to afford prompt and material benefit.

### Case Report

A 35 year old, white, former hospital attendant was admitted to the receiving ward of the VA Hospital, Outwood, June 24, 1949 with complaints of dyspnea, fever and recent weight loss of 40 pounds. Far advanced, pulmonary tuberculosis had recently been diagnosed at Nichols VA Hospital, Louisville, by X-ray and sputum which were positive for acid fast bacilli. A diarrhea had been present intermittently since 1944, when he had been stationed in the Philippines but repeated stool examinations for parasites were negative.

Past history was otherwise non-essential.

On admission to Outwood, sputum was positive for acid fast bacilli and X-ray of the lungs showed extensive infiltration and cavitation in both lungs and temperature ranging around 100 degrees. Kahn was negative, CBC and urine analysis essentially normal and sedimentation rate by the Cutler Method was 27. On September 22, 1949, a severe pulmonary hemorrhage occurred continuing until the next day. At this time a red blood count showed 3,120,000 erythrocytes and hemoglobin of 8.75 grams percent. Preparation for a blood transfusion was made and as an emergency measure 250 cc of non-irradiated plasma was given intravenously (the use of non-irradiated plasma has since been discontinued in the VA Hospitals). Following this no further hemorrhage occurred and as the patient's condition appeared satisfactory, the transfusion of blood was not given. Pneumoperitoneum was initiated on September 13, 1949 and on October 5, 1949, dihydrostreptomycin, one gram daily and para-amino-salicylic acid, 12 grains daily, was started. Following this therapy, temperature subsided to practically normal limits and he was transferred to a treatment ward. On December 14, 1949, there were some complaints of abdominal distress and a mild diarrhea developed.

On December 19, 1949, nausea and occasional vomiting occurred. On December 25, 1949, icterus was noted. There was some hepatic tenderness present but no noticeable enlargement of the liver. Pneumoperitoneum, dihydrostreptomycin and PAS was discontinued on December 27, 1949, and a low fat diet instituted supplemented by vitamins orally and parenterally. However, jaundice and anorexia increased and patient's condition deteriorated rapidly. On January 5, 1950, he was stuporous and incontinent with profuse perspiration and cyanosis. At this point it was thought that the administration of plasma on September 23, 1949, approximately 90 days previous might have caused a homologous serum jaundice and as aureomycin had been reported successful in several virus diseases it was decided to try its effects in this case. Therapy was initiated with a dosage of 500 milligrams every six hours. The initial dose was given with some difficulty due to his stuporous condition. Marked improvement in general condition resulted in the next few days and definite increase in appetite was noted. On account of poor general condition of the patient, liver biopsy and differential diagnosis of the jaundice was not attempted. Icteric index on January 3, 1950, was 113 with 12 milligrams percent bilirubin. Complete blood count on this date was normal. On January 30, 1950, the icteric index had fallen to 67 units and on April 26, 1950 to eight units. The non-protein nitrogen remained normal on several occasions and the urine was negative except for the presence of bile. Oral galactose tolerance test on January 18, 1950 showed 3.9 grams excreted and total protein January 30, 1950, was 6.76% with albumin 3.5% and globulin 3.2%.

**Available Food Supply:** During the decade 1938 to 1948 the available per capita food supply of the world decreased by about 6%. Although the total amount of calories and proteins available has increased 1 to 2%, Dr. Charlotte Chatfield and associates of the Food and Agriculture Organization of the United Nations find that the world population has grown more than 8% during the same period. Inequalities in food distribution have also become more severe. In regions where prewar food consumption was low, the situation has grown worse, while regions with a good prewar supply have either maintained or raised that level.

While this episode of jaundice may have been due to hepatic damage caused by administration of streptomycin and PAS, the cessation of these drugs was not followed by improvement. Liver damage by streptomycin is rather rare and with dihydrostreptomycin even more so. Regan and Hinshaw in their report on streptomycin, dihydrostreptomycin and tuberculosis, page 502, state "in no case was there evidence of depression of hemopoietic activity and liver function was not obviously damaged by medication (dihydrostreptomycin) even in two patients with cirrhosis." The question of hepatic toxicity of para-aminosalicylic acid is still under investigation with no reports of hepatic toxicity, therefore, it seems fair to conclude in this case that the cause of the icterus was a hepatitis, due to the administration of non-irradiated plasma three months earlier. It appears that this acute hepatitis super-imposed upon the far advanced, active, pulmonary tuberculosis was sufficient to overwhelm the patient until suppressed by the aureomycin. At the present time he continues to run some fever due to his pulmonary tuberculosis but shows no effect of his hepatitis.

### Summary

A case of pulmonary tuberculosis is reported, complicated by a homologous serum jaundice, 90 days after injection of non-irradiated plasma. The marked improvement following the administration of aureomycin would warrant further trial of this drug in hepatitis of viral origin.

Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the author are the result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

**A triple sulfonamide mixture containing** equal amounts of sulfadiazine, sulfamerazine, and sulfacetimide will cure most children with acute bacillary dysentery. Dr. David Lehr and associates of New York Medical College, New York City, recommend a daily dosage of 0.2 gm. of the triple sulfa mixture per kilogram of body weight. Sodium bicarbonate need not be given. Of 24 children with acute bacillary dysentery due to *Shigella sonnei*, 20 were cured by this therapy. Sulfadiazine alone or a non-absorbable preparation, phthalylsulfacetimide, produced cures in a smaller percentage of patients.



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## **WHOSE RESPONSIBILITY IS THE PUBLIC HEALTH?**

The medical profession in Kentucky occupies a more favorable position in regard to responsibility for public health than is the case in many other states. In Kentucky the practicing physician has the ultimate responsibility for community health as well as for the health of the individuals who are his patients.

Administration of the State Department is a legal function of the State Board of Health. The majority of the members of the State Board of Health are appointed by the Governor from physicians nominated by the Kentucky State Medical Association.

KRS 212.020 requires the State Board of Health to appoint, "three intelligent and discreet licensed and practicing physicians residing in each county who, together with the County Judge and one person appointed by the fiscal court of each county, shall constitute a local board of health for the respective counties in which they reside."

KRS 212.140 states, "A county department of health shall be governed by the members of the county board of health." Certain specific duties and responsibilities of county boards of health are delineated in the statutes.

It is evident that the legislators of our Commonwealth placed control of the public health in the hands of the medical profession. This is as it should be. No other group has the knowledge required to properly assume the responsibility.

This arrangement insures the medical profession that in Kentucky public health programs will be carried out in such a manner that the private practice of medicine will not be encroached upon by government medicine in disguise. Every community needs, and must have, the protection that a properly functioning health department can give to the health of its people, but the work of the health department lies completely outside the field of private

practice and the department should engage in no activities that can be accomplished as well, or better, by practicing physicians. It is the duty of the medical profession, as represented by a majority of the members of the county board of health, to see that the rights of the profession are properly protected. Kentucky physicians are, for the most part, aware of this duty and are diligent in this phase of their responsibility.

The same statutes, however, that gives the profession this protection also charges the profession with the duty of seeing that the county health department carries out an efficient program that meets the public health needs of the community. This is the responsibility that is too often completely neglected by the doctors of the community. Even by those who are members of the county board of health. Many board of health members look upon their appointment as a sort of dubious honor but do not accept the responsibilities that accompany it.

We know of no more important way that a physician can simultaneously serve his profession and the people of his community than as an active, interested member of his county board of health.

County health departments will never accomplish the purpose for which they exist until they are actively supported and guided by the medical profession of their communities. Only when the profession assumes the responsibility with which it is legally charged will morbidity and death rates from preventable diseases reach their minimum.

Some county boards of health do not hold meetings with any regularity. Many doctors who are members of boards of health so neglect their duties that for all practical purposes the County Judge becomes the board of health. These same doctors may vigorously oppose, at least intellectually, the idea of administration of medical programs by laymen. They also may be dissatisfied with the manner in which the health unit is operated. They may feel that it is engaged in programs which encroach upon private practice or they may feel that it is accomplishing nothing that is worthwhile. In either in-

stance it is their duty to correct the situation. The people have a right to look to their county board of health and to hold it legally and morally responsible for the proper functioning of the department.

The dismal situation pictured above happily does not exist in all of Kentucky's counties. There are some boards of health which meet regularly and study the health problems of the community and give active medical guidance to the public health programs. Those fortunate counties invariably have good health units that are of great value to their communities, and which are enthusiastically supported by the county medical society.

We would like to point to the Daviess County Board of Health as a splendid example of a board that assumes and fulfills its obligation to the profession and to the people of Daviess County. This board holds regular meetings. It is keenly interested in the administration of its health unit; in its programs and in its budget. It is interested in seeing that the unit receives sufficient funds to operate efficiently. The physician members personally stimulate local appropriations. Recently Drs. R. Haynes Barr and Wm. L. Woolfolk, physician members of the board of health, together with Dr. E. A. Willis, dental member of the Daviess County Citizens Health Committee, accompanied their health officer, Dr. Charles E. Brenn, to Louisville to discuss certain problems of their health unit with the State Health Commissioner. Willingness to absent themselves from their practices and to pay their own expenses incurred in making the trip further manifested their sincere interest in their county health department and demonstrated acceptance of responsibility for its continued efficient operation. The invaluable service that these busy doctors are rendering to the well-being of the people of Daviess County and to their fellow members of the Daviess County Medical Society deserves much appreciation.

When Kentucky has 120 such boards of health, her public health problems will be solved and they will be solved in a manner that affords adequate protection of the people from preventable diseases and in a manner that is acceptable to the profession.



## THE AMERICAN MEDICAL EDUCATION FOUNDATION

Immediately after making an initial donation of a half million dollars to medical schools, A.M.A. organized the American Medical Education Foundation as a not-for-profit corporation under the laws of the State of Illinois. The foundation is to receive and distribute gifts which are expected to come from the profession and from other sources. The Commissioner of Internal Revenue has been asked to rule that contributions to the fund may be deducted in computing income taxes. A board of eleven directors is to guide its affairs.

Medical schools must receive financial assistance from some source if present standards of medical education are to be maintained. In recent years income from endowments has been markedly reduced. There have been few large benefactions received. Due to inflation and ever-rising costs of operation, medical schools find themselves in an alarming financial condition.

In his presidential address at the Cleveland A.M.A. Meeting, Dr. Elmer Henderson placed the responsibility upon the profession when he said, "We must make it clear that the profession is not indifferent to these problems. Let us clearly face our obligation individually and collectively to provide significant financial assistance to the medical schools."

Individual physicians are urged to contribute to the Foundation. Although smaller sums will be gratefully received by the Foundation, doctors are asked to consider giving \$100 annually.

The money will go to medical schools with absolutely no strings attached as to how it must be spent. Schools can include the money in their strained budgets wherever they feel it will do the most good.

The point has been made that many physicians will welcome the opportunity to have a part in providing the medical education for future members of the profession since practically all practicing physicians received their own education at a fraction of its cost in the "good old days" when schools were in better financial condition.

The only apparent alternative to the medical profession's assumption of the obligation to assist medical schools through their financial crisis is to accept Federal aid. Unfortunately, none of the proposed bills that have been introduced in Congress has been free of strings and none has been acceptable to the profession.

Freedom is often expensive. It costs to secure freedom and it costs to maintain our freedom. This is an example.

A.M.A.'s generous donation is one of the most praiseworthy and constructive actions that has ever been taken by medicine. It has been accepted as concrete evidence of the profession's genuine desire to solve its problems.

Each physician is urged to accept this challenge and to mail his contribution at once to the American Medical Education Foundation, 535 North Dearborn Street, Chicago 10.

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## STUDENT AMERICAN MEDICAL ASSOCIATION

At last medical students are to have a part in organized medicine. During the latter part of December, delegates from the student bodies of 48 medical schools with a total membership of 15,855 met in A.M.A. headquarters in Chicago and organized the Student American Medical Association.

The new organization has as its objectives the advancement of medicine; contribution to the welfare and education of medical students; familiarization of its members with the purposes and ideals of the medical profession, and preparation

of its members to meet the social, moral and ethical obligations of the profession.

The Association will be made up of academic societies in medical schools of the United States which bear the approval of A.M.A.'s Council on Medical Education and Hospitals. Each society must have a membership of at least one-fourth of the student body, or 85 students, whichever is the smaller number.

Each constituent society is to have an advisory committee composed of the Dean of the school or his appointed representative; two faculty members elected by the

students, and a representative of the county and state medical societies. The president and vice-president of the Student House of Delegates are to represent the Association at A.M.A.'s House of Delegates, provided the Constitution of A.M.A. is changed to permit such representation.

Organization of this Association is an important move. Many physicians practicing today do not have an adequate conception of the vast contribution that the American Medical Association makes to the profession and have even less knowledge of the important work done by the Association to protect the health of our people. Perhaps A.M.A. has not sold its self to the profession as it should. There are several films now available that present the tremendous scope of A.M.A.'s ac-

tivities and they are of great value in educating the profession itself concerning the parent organization.

Young physicians especially need to know at the beginning of their practice just how important organized medicine is to the well-being of the profession and to be familiar with A.M.A.'s many services and how to utilize them to the greatest advantage.

Through knowledge gained by membership in the student association, young physicians will enter practice ready to step in as enthusiastic members of their county and state medical societies and be better prepared to take their places among their fellow workers and as a citizen of their communities.

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## BLUE SHIELD PHYSICIANS MANUAL

Mr. D. Lane Tynes, Executive Director of Kentucky Physicians Mutual, Inc., has announced that a Blue Shield Physicians Manual will shortly be mailed to all participating physicians. The Manual will be heartily welcomed by physicians since it will contain the answers to many questions that arise concerning the operation of the Blue Shield Plan.

The Manual is in the form of a manila folder which will fit standard office files. It contains a brief history of Blue Shield, nationally and in Kentucky and gives complete information concerning enrollment procedures and filing of claims and has the complete schedule of indemnities.

Such a Manual has been badly needed by physicians ever since the plan has been in operation. Very few physicians have had sufficient information to intelligently answer their patient's questions con-

cerning the Plan.

Both the doctor and his secretary are urged to thoroughly familiarize themselves with the Manual. The doctor certainly will want to know more about the operation of the Plan and his secretary needs to be thoroughly familiar with the procedures so that she may be able to relieve the doctor of filling out forms and other details. She should also be used as a source of information for patients who are interested and thus save the doctor's time.

Blue Shield is to be congratulated upon the excellence of the Manual. We prophesy that each doctor who reads this Manual will become more keenly aware that the Blue Shield Plan is his Plan and will be proud of this effort to provide non-profit voluntary health insurance for the people of Kentucky.

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## EDITORIAL COMMENTS

:—: Doctors do not like to be glamourized. They resent the "Dr. Kildare" type. Nevertheless, a recent survey conducted by Dr. Carroll L. Birch, professor of medicine, University of Illinois College of Medicine, indicates that self dedication to human welfare is a dominant motive driving a large percentage of students to the arduous discipline of medicine.

:—: Among the 166 students selected for the freshman class, 53 specifically listed altruistic, humanitarian motives for entering medicine. Admiration for the family doctor or for a physician relative motivated 28 others. Some of this group were moved by such heroic figures as Albert Schweitzer, the famous medical missionary. Ten responded to the call of medi-



cine due to religious influence. Interest in science inspired 42 applicants.

Only 12 listed desire to make money and only eight coveted the prestige of the physician.

A complete report of the study may be found in the January issue of the Illinois Medical Journal.

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**The U. S. P. H. S. has allocated \$600,000** and is expected to attempt to obtain \$1,500,000 additional funds, to research on blood collection separation and preservation. The activities will be divided into three phases: 1. Basic research on the separation, purification, storage and use of formed elements of blood which can act as substitutes for whole blood. 2. Developmental research to improve methods of blood collection. Dr. Charles A. Doan, Ohio State University School of Medicine, will receive a grant in excess of \$200,000 to adapt research to large scale production of blood fractions and for the development of special equipment such as plastic transfusion kits. 3. Clinical research in the relative effectiveness of whole blood and blood substitutes in the treatment of burns, shock and radiation therapy.

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**"Physician Participation in School Health Services"** will be the subject of a report on a school health survey which has been completed by the A.M.A. Bureau of Health Education, according to Dr. George F. Lull, Secretary and General Manager of A.M.A.

Dr. Lull states that the survey shows a level of interest, understanding and participation in school health services on the part of medical societies which is very gratifying.

The questionnaire was sent to 1,000 local medical societies, one-third of those replying have a school health committee. One-quarter of the communities have school health councils, nine tenths of which include medical society representation. School physicians, chiefly part time, are reported by slightly more than half of the medical societies.

"In general," Dr. Lull says, "the report shows that individual physicians and medical societies are active in many aspects of school health services. In some areas there is need of further support from the profession."

**Comparative availability of medical** care to the people now and in former years must be interpreted in the light of a number of factors according to Frank G. Dickinson, A.M.A. economist. Better roads and better transportation conserve the doctor's time and permit him to see many more patients per day than was formerly possible. Due to improved drugs and antibiotics, the treatment time of many conditions has been greatly reduced. These together with other factors permit Dr. Dickinson's estimate, "The amount of medical care which 1,000 physicians delivered in 1949 was at least one-third greater than the amount 1,000 physicians could deliver in 1938."

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**The "Decline of Ewingism" is the title** of an editorial by Dr. H. Sherman Baketel in the December issue of Medical Economics. The point is made that nearly 90% of congressional proponents of compulsory health insurance received a sound shellacking at the polls in November and although Ewingism is not completely dead, it has turned into a first-class political liability.

Dr. Baketel says, "Thus medicine is given two years of grace—two years to accentuate the positive, to extend and improve the voluntary plans, to clinch its case through action as well as through words." Our response to these words is a hearty "Amen."

It behooves us in Kentucky to take full opportunity of this two years of grace. By consolidating the gains made in the past two years, medicine can free itself, perhaps forever, from the menace of socialism.

There is no better way to "accentuate the positive" in Kentucky than by freely supporting our own Blue Shield Plan. The next two years should see many thousands of Kentuckians enrolled in voluntary plans.

Dr. Baketel concludes, "Once before (in 1946) when faced with a similar opportunity, we frittered it away. This time let's do the job right. It's the only sure death sentence for Ewingism."

In Kentucky we must not permit negativism and a false sense of security to "fritter away" the opportunity that is ours.

**Firms that advertise in this Journal** pay a major portion of the cost of publishing this magazine. With the inflated costs of paper and labor, the financial burden to the Association in getting out the Journal, becomes heavier. All things equal, members are urged to use the products of firms that support this Journal.

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**Blood donations must be tripled this year** if pyramiding demands of the military and civilian hospitals are to be met, according to a statement released by the American Red Cross.

More than a million pints of blood will be required by the Defense Establishment by July 1, exclusive of everyday demands in civilian hospitals was the estimate of E. Roland Harriman, Red Cross President.

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**As a means to make their Blue Shield Plan** more effective, the eight doctors in Woods County, Oklahoma decided to make their cash indemnity plan operate in their county as though it were a service plan. This means the doctors agreed to accept the plan's indemnities as full payment for services rendered to individuals whose annual incomes are less than \$1,500 and to families earning less than \$4,000 annually.

Dr. B. B. Ensor, who spearheaded the movement said, "There is no need for government interference to provide adequate low-cost medical care. This plan gives the medical profession a chance to prove it.

"The doctors are the guardians of the Blue Cross and Blue Shield plans and must assume the responsibility of seeing that they work. This is a community service to meet a community need."

Doctors in 15 to 20 other Oklahoma counties are expected to voluntarily follow suit.

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**The American National Red Cross** has been asked to perform the huge task of training twenty million persons in first aid including all civil defense workers, and to serve as the official procurement agency for blood for the armed forces and to coordinate a blood program to meet civil defense needs. In addition, as a part of the civil defense program, Red Cross is to train nurses aides and give instruction in home nursing.

These are monumental undertakings in important phases of civil defense and the Red Cross will need the cooperation of every physician.

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**The use of radioisotopes by hospitals,** laboratories and schools has increased 36 fold in the past year. The Atomic Energy Commission has reduced the price to \$10 which covers shipping charges.

Because of its relatively low cost and ease of handling, radio cobalt is expected to replace radium in the treatment of cancer. Radioactive iodine is being used in thyroid conditions and isotopes have been found valuable in tracing and treating some malignancies.

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**Kentucky physicians will be unusually** well represented at the Southeastern Surgical Congress Graduate Assembly which will hold its Nineteenth Annual Meeting in Hollywood, Florida on April 11-14, 1951.

Dr. C. C. Howard, Glasgow, President of the Congress, will read a paper, "Accidents and a Proposed Program for Prevention"; Dr. Elmer L. Henderson, Louisville, A.M.A. President, will speak on "1951—Medicine's First Year of Grace"; Dr. Herman Mahaffey, Louisville, is to read a paper entitled, "Fibrosarcoma of Ileum with Report of Two Cases"; Dr. Clyde C. Sparks, Ashland, is to speak on "Common Benign Breast Lesions." Dr. J. Duffy Hancock, Louisville, is first vice-president of the Congress.

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**President Truman has not permitted** the defense effort with all of its demands upon the national economy to deter him in his efforts to extend his "Fair Deal" program, which includes compulsory health insurance. He is in fact attempting to connect his pet schemes with national defense.

During our "two years of grace," doctors must keep a watchful eye upon the horde of bills that are being introduced in Congress and continue to let their legislators know how they feel about all of them that tend to socialize medicine. As has been so well proved, this activity will help the bills to meet their deserved fate and preserve American medicine.



# ORGANIZATION SECTION

## **Treating Atomic Casualties Course Offered County Societies**

Members of Medical Societies which have cities of the second and third classes in their jurisdiction in Kentucky will have an opportunity to take a three-hour course in the treatment of injuries growing out of atomic warfare, Pat R. Imes, M. D., Louisville, Chairman of the Committee on Emergency Medical Service, has announced.

Dr. Imes said his committee is actively co-operating with P. M. Crawford, M. D., of the State Department of Health, who is Deputy Director of Civilian Defense Medical Service.

The plan is to contact these County Medical Societies through their Secretaries to learn if fifty per cent of the members of each Society will agree to attend this special course if one is provided.

When the County Society indicates its willingness to cooperate, a carefully picked team of instructors will be sent into each county that desires the instruction. A mutually agreeable date will be arranged for holding the course.

Various officials of our State Association and the State Civilian Defense are working to keep Kentucky apace with other states in planning for the treatment of possible atomic warfare casualties.

Other members of the Committee on Emergency Medical Service are Guthrie Y. Graves, M. D., Bowling Green; Orion L. Higdon, M. D., Paducah; W. Mountjoy Savage, M. D., Maysville; Leland E. Payton, M. D., Lynch; and Francis M. Massie, M. D., Lexington.

## **Class Reunion to be a Feature of Centennial Meeting**

Class reunions for classes that graduated in 1901, 1911, 1921, 1931 and 1941 at the University of Louisville School of Medicine will be held during the Annual Meeting of the Association in Louisville, October 2, 3 and 4 as a part of the Association's Centennial Celebration.

Arrangements for this feature of the Centennial were made by the Association with officials of the University of Louisville School of Medicine and Leslie Shively, Alumni Secretary of the University.

These reunions are ordinarily held in connection with the University's Seminar held

early in June of each year. Due to the kindness of the University officials, the Association was able to make these plans.

Members of the above five classes will be sent ample information on the arrangements for each class in due course.

## **Medical School to Participate in 100th Anniversary Program**

Plans for the participation of the University of Louisville School of Medicine in the Centennial Celebration of the Association the first week in October are being developed by Herbert Clay, M. D., Director of the Post-Graduate Refresher Training Department of the School of Medicine.

Arrangements have been made between the Association and the University calling for a full day's program to be sponsored by the Medical School on Friday, October 5. Outstanding speakers are now being scheduled to present a therapy seminar. The scientific program sponsored by the Association will be presented October 2, 3, and 4.

Dr. Clay said, "We believe that every effort should be made to have the strongest possible scientific program for the Centennial, and we are glad that the University will participate in this historical meeting."

## **Joint Meeting Planned for March 29 in Second Councilor District**

Physicians and members of the Woman's Auxiliary of the Second Councilor District will have a joint dinner meeting, Thursday, March 29, 1951, in the Skyline Room at Gabe's Restaurant in Owensboro.

"Epilepsy" will be discussed by Ephraim Roseman, M. D., Professor of Neurology at the University of Louisville School of Medicine, the featured speaker of the scientific program.

The arrangements for the meeting are being made by Walter L. O'Nan, M. D., Henderson, President of the Second District Medical Society, in cooperation with R. Haynes Barr, M. D., Owensboro, Councilor for the District.

The physicians and their wives will have their dinner together and following a short exercise, the women will leave the men and go to another room for their Auxiliary meeting.

At the time this was written, plans had not

been completed for the full program. It was learned, however, that members of the official family of the Association would be on the agenda.

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### **U. of L. Attendants Vote to Join Student A. M. A.**

More than 120 Medical Students at the University of Louisville have indicated their desire to set up an organization that will become a constituent part of the Student American Medical Association.

John D. Hummel from Williamsburg, Kentucky, a junior at the Medical School, has sparked this movement at the local school. Plans call for a temporary chairman and secretary who will help perfect the constitution and bylaws of the Louisville chapter first. After this has been accomplished, a regular election will be held, Hummel said.

The Student A.M.A. came into being when representatives of 48 medical schools in this country, representing 15,855 students, met at the A.M.A. headquarters office in Chicago, December 28 and 29. Hummel, a member of the University of Louisville Student Council, represented the Kentucky school.

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### **U. of L. - K. S. M. A. Seminar to be Held June 4 and 5 in Louisville**

June 4 and 5 will be the dates of the 1951 Medical Seminar of the University of Louisville and the Kentucky State Medical Association, Herbert L. Clay, M. D., Director of Post-Graduate Refresher Training, has announced.

This refresher course is open to all physicians in Kentucky and surrounding states who wish to attend, Dr. Clay said. The Seminar will be held in conjunction with the graduation exercises of the Medical School.

The program for the Seminar will include the men of unusual ability and will be announced soon. Eight hours credit for formal training will be given attending members of Academy of General Practice.

Medical organizations sponsoring the program are: Jefferson County Medical Society; Kentucky Academy of General Practice; Kentucky Chapter of National Foundation for Infantile Paralysis; Kentucky Committee of Fractures and other Trauma of the American College of Surgeons; Kentucky Division of the American Cancer Society; Louisville Regional Blood Center of the American Red Cross; and Kentucky Heart Association.

### **Dr. Henderson Honored by Cuba at Havana Ceremony January 14**

The Carlos J. Finlay Award for distinguished service in the field of medicine and public health, the highest honor that can be bestowed in the field of medicine in Cuba, was given to Elmer L. Henderson, M. D., Louisville, President of the American Medical Association, the World Medical Association, and Past President of the Southern Medical Association, in a ceremony held at Havana, Cuba, Sunday, January 14.

Dr. Jose A. Rubio Padilla, Minister of Health of Cuba, a cabinet post, presented the award after giving an appropriate address. The award is evidenced by the beautiful Finlay medal and a scroll signed by the President of the Republic of Cuba.

Others receiving the award were George F. Lull, M. D., Secretary and General Manager of the American Medical Association, Chicago, Illinois; Tom D. Spies, M. D., Director, Nutrition Clinic, Hillman Hospital, Birmingham, Alabama, and Professor and Head of Department of Nutrition and Metabolism, Northwestern University Medical School, Chicago, Illinois; Paul de Kruif, M. D., Author and Science Writer for "The Reader's Digest," Holland, Michigan; and Mr. Clyde P. Loran, Secretary and General Manager, Southern Medical Association, Birmingham, Alabama.

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### **Bill Authorizing V. A. to Appoint Chiropractors is Introduced**

A bill "to authorize the appointment of Doctors of Chiropractic in the Department of Medicine and Surgery of the Veterans Administration" has been introduced in the House of Representatives by Democratic Representative Magee of Missouri.

The bill, known as H.R. 1368, was introduced January 12 and referred to the House Committee on Veterans' Affairs.

Experienced observers feel it is unlikely that H.R. 1368 will be brought out of the Committee.

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### **Seminar in Pediatrics, March 9, 16 and 30, To Be In Lexington**

The Post-Graduate Seminar in Pediatrics for Physicians, held under the auspices of the University of Louisville School of Medicine, will present the second half of its program at the St. Joseph Hospital in Lexington, March 9, 16 and 30, A. J. Steigman, M. D., Chairman, has announced.

Dr. Steigman, who is Professor of Child Health at the Medical School, said the first half of the series was presented February 9, 16, 23 and March 2.



The Seminar is presented by the Kentucky Child Health Foundation and is sponsored by the Kentucky Chapter of the Academy of General Practice, the Kentucky Chapter of the Academy of Pediatrics, and the Kentucky State Medical Association.

Physicians interested in attending the Seminar should contact Dr. Steigman at 323 East Chestnut Street, Louisville.

### First District Holds Initial Session at Fulton, January 17

Forty-three physicians and their wives of the First Councilor District attended the first of four councilor meetings planned for 1951 at Fulton, January 17, according to an announcement by J. Vernon Pace, M. D., Paducah, District Councilor.

Alex J. Steigman, M. D., Professor of Child Health at the University of Louisville, discussed "The Early Diagnosis of Poliomyelitis." Dr. Steigman was introduced by J. E. Dunn, M.D., Paducah pediatrician. Dr. Steigman's paper included colored pictures of the varied physical signs of early infection in children.

The Fulton-Hickman County Medical Society was host to the First District physicians and their wives and Russell Rudd, M. D., president of the Society, presided at the meeting. Councilor Pace spoke briefly on the activities of the Association. Other meetings are planned for the First District at Mayfield, Murray, and Paducah this year.

### Should Statements be Itemized?

The following item appeared in a recent issue of the Secretary's Letter of the Illinois State Medical Association. It has been widely quoted in other state medical association publications.

### V. A. Reports on Home Town Care

The Kentucky State Medical Association, in 1947, entered into a contract with the Veterans Administration, relative to the supplying of medical care to veterans in the local community.

O. P. Miller, M. D., Chief Medical Officer of

"Would you pay your bill at the garage if it came to you: 'Repair on 1948 car..\$64.32'? You'd much rather know that \$8.00 went for checking the front end alignment; \$1.25 for adjusting brakes; \$1.25 for switching the tires, and that parts amounted to \$22.75 and the rest was labor.

"Perhaps Mrs. Jones didn't understand the charges for Junior's case of infectious mononucleosis; maybe she didn't know what laboratory work is. Did you explain to her exactly what was wrong with Junior? Did you tell her why laboratory work had to be done? Does your bill carry the statement that you made a night call on Wednesday, June 20th? If it does, maybe she'll remember how glad she was to see you.

"Or did you send Mrs. Jones a statement for 'Services rendered'?

"Think it over. Put on Mrs. Jones' size 5½ shoes for a while and see if they pinch—just a little."

### Obstetricians to Meet April 6 and 7 in Ashland

The fourth Annual Meeting of the Kentucky Obstetrical and Gynecological Society will be held in Ashland, Kentucky, on April 6-7, J. B. Marshall, M. D., Louisville, Secretary of the Society, announced.

Dr. Conrad Collins, Professor of Obstetrics and Gynecology at Tulane University, New Orleans, Louisiana, will be the guest speaker.

The headquarters for the meeting will be at the Henry Clay Hotel, and registration will begin at 8:00 A. M. on April 6. Dr. Marshall said that all physicians who are interested are cordially invited to attend the scientific sessions.

the Regional Veterans Administration Office in Louisville, at our request was kind enough to supply the Journal with the figures listed below, covering the operation of the contract.

Any member of the Association who is not a participating physician in "Home town" medical care agreement and who wants information on it should contact the Headquarters office.

	Number of Authorizations	Amount of Authorizations
July 1947 through June 1948—Medical Treatments	6,065	\$74,760
Medical Examinations	4,003	39,791
July 1948 through June 1949—Medical Treatments	6,913	67,555
Medical Examinations	883	6,274
July 1949 through June 1950—Medical Treatments	7,435	69,972
Medical Examinations	512	2,037
July 1950 through Jan. 1951—Medical Treatments	4,360	48,732
Medical Examinations	241	2,197

### Noted Educator Named to Red Cross Blood Post

Dr. Russell Landrum Haden, medical educator and recently head of the Department of Medicine at the Cleveland, Ohio, Clinic, has been appointed medical director of the Red Cross National Blood Program, General George C. Marshall, the organization's president has announced.

Dr. Haden will direct the medical aspects of the blood program as it is expanded to provide blood, plasma and other derivatives for the nation's hospitals and for military and civil defense needs. He will work with Dr. Ross T. McIntire, chairman of the blood program's committee on medical policies and procedures.

### A. C. P. to Meet at St. Louis April 9-13

The 32nd Annual Session of the American College of Physicians will be held at St. Louis, Missouri, April 9-13, 1951.

The President of the College, William S. Middleton, M. D., Madison, Wisconsin, is in charge of the scientific program. Ralph Kinsella, M. D., St. Louis, is making the local arrangements.

Aubrey Gates, Field Director of the Rural Health Committee of the A.M.A., spent two days in Kentucky early in January with Walter L. O'Nan, M. D., Henderson, Chairman of our own Rural Health Committee, and the Headquarters Office. Mr. Gates is doing an excellent work, and we look forward to a return visit in the Spring.

The National Conference on Chronic Diseases will be held at the Edgewater Beach Hotel in Chicago, March 12, 13 and 14. The Conference is sponsored by the Commission on Chronic Illness, in cooperation with the U. S. Public Health Service and the National Health Council. The Commission was founded in 1949 by the A.M.A.

The American College of Chest Physicians will hold its fourth annual postgraduate course in diseases of the chest at the Hotel Warwick in Philadelphia, Pennsylvania, March 26-30. Chevalier L. Jackson, M. D., is Chairman of the Postgraduate Course Committee. Applications should be sent to the A.C.C.P., 500 North Dearborn Street, Chicago 10, Illinois.

The Southern Medical Association will hold its forty-fifth annual meeting at Dallas, Texas November 5, 6, 7 and 8, 1951.

The International Academy of Proctology will sponsor a teaching seminar on proctologic subjects in New York City, April 7, 1951. For further information, communicate with William L. Iederman, M. D., 1819 Broadway, New York 23.

Paul M. Crawford, M. D., Deputy Director of Health Services in the State Civilian Defense Organization, was instrumental in arranging for the course given in Louisville January 25, in the Brown Hotel, to the physicians of Louisville and vicinity on the treatment of casualties growing out of atomic warfare. Medical officers from Fort Knox were the instructors in this course.

A total of 736,000 prescriptions have been filled for veterans under the home town pharmacy program during 1950. A release from the Veterans Administration said this figure, which covers the entire nation, was 135,000 prescriptions more than those filled in 1949.

The American Academy of General Practice will hold its annual assembly March 19-22, at San Francisco. The Palace Hotel has been designated as the convention headquarters. The Congress of Delegates will meet on March 18.

### General Practice Award

The Academy of General Practice of Kentucky is offering an award for the best paper submitted on any subject pertaining to general practice. Dr. D. G. Miller, Jr., Morgantown, Kentucky, Secretary-Treasurer of the Kentucky Academy of General Practice, has supplied the rules governing the award as follows:

1. Any general practitioner in Kentucky may submit a paper based on original work he has done as a general practitioner.
2. Paper to be typewritten, double spaced, on one side of plain white paper, bearing no name, sealed envelope to be clipped to paper containing name and address of physician submitting the paper.
3. Paper must be submitted before July. Send to Academy office in Morgantown, Kentucky.
4. May be on any subject the writer wishes.
5. Will be judged by three University of Cincinnati physicians.
6. Award will be based on originality and practicability of research.



## KENTUCKY PROCUREMENT COMMITTEE NEWS

by

A. Clayton McCarty, M. D., Chairman

### Procurement Committee to Ask For Additional Information

The cooperation of the medical profession in Kentucky is urged by the Kentucky Procurement Committee in its attempt to set up its records in accordance with the methods prescribed by the National Advisory Committee to Selective Service.

Every Kentucky physician will be sent the new National Advisory Committee form in the near future, it was announced by A. Clayton McCarty, M. D., Chairman of the Kentucky Procurement Committee. It is requested that these forms be completed immediately upon receipt and returned to the Headquarters office of the Kentucky State Medical Association, 620 South Third Street, Louisville.

It was explained that the Kentucky Committee was reluctant to approach the physicians a second time for information, but Dr. McCarty said, "In addition to the obvious advantages of conforming to the system developed by the National Advisory Committee, the added knowledge will help our committee to serve our doctors in a more equitable fashion."

Other physician members on the Kentucky Procurement Committee are: J. Duffy Hancock, M. D., Louisville; Charles B. Billington, M. D., Paducah; Glenn U. Dorroh, M. D., Lexington; R. Arnold Griswold, M. D., Louisville; and L. O. Toomey, M. D., Bowling Green.

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### Opinions Indicate Medical Officer Liable For Services Rendered

Physicians entering military service should think twice before discontinuing their professional liability insurance, it would appear from opinions that have been handed down by the Judge Advocate General and the Surgeon General of the Army.

A physician is under the same obligation to exercise due and ordinary care in the rendition of professional services in the Armed Forces as he is in private practice. The Surgeon General's office states, moreover, the medical officer is liable for negligence in services rendered to the members of the Armed Forces as he is in private practice and is answerable in the same degree.

A draftee, it has been held, does not sacrifice his civilian rights to sue and be sued while being inducted into or serving in the Armed

Forces. This opinion of the Judge Advocate General should dispel any impression that an enlisted man cannot bring a malpractice suit against a medical officer.

Still another reason exists for the doctor entering the Service to think seriously before discontinuing his professional coverage. Oftentimes the departing physician enters into either loose or contractual agreement with another physician or other physicians to look after his patients. It is, therefore, well within the realm of possibility that a liability would accrue to the departing doctor as a result of services rendered by the man with whom the arrangement was made.

The United States Supreme Court ruled in October of 1950 the government could not be held responsible for the acts of an army medical officer during an operation under the Federal Tort Claims Act. According to the evidence a towel, with U. S. Army printed on it, was left in the abdomen of an enlisted man following surgery.

This decision adequately supports the opinion of the Judge Advocate General and Surgeon General that the government is not liable for acts of medical officers. It underlines the danger of the medical officer who assumes that "working for the government" carries immunity from responsibility for personal acts.

Any member desiring additional information on this subject should contact an informed insurance representative or the Headquarters Office of this Association.

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### Selective Service Registers 851 In Priorities III and IV

A total of 851 physicians registered in Kentucky at the January 15, 1951, registration held under Public Law 779, State Selective Service Headquarters have announced.

A total of 301 physicians were registered in Priority III and 550 in Priority IV. In the same registration, 268 dentists registered in Kentucky, with 152 falling in Priority III and 116 in Priority IV.

This January 15 registration was called a "name registration" by Selective Service. Additional information will be asked of the priority groups as needed, Selective Service has indicated.

In the January 15 registration, 26 veterinarians registered in Priority III and 19 in Priority IV.

### **Navy, Air Force Reserve Discontinue Commissions to Priority II**

The Navy has discontinued accepting applications for commissions from physicians in Priority II, as described in Public Law No. 779, who desire to join the Medical Corps of the Naval Reserve, a recent Department of Defense release stated.

The Surgeon-General of the Air Corps has announced that his branch of the Service will not accept applications from men in Priority II for reserve commissions in the medical Corps. However, the Air Corps will accept applications from men in Priority II for the regular service, the applicant agreeing to serve at least three years in the regular Air Force.

Applications for commissions in the Naval Reserve Medical Corps and the Medical Corps of the Air Force Reserve from men in Priority I have not been accepted since last fall.

### **Advantage in Delaying Acceptance of Commission Removed**

Delay in accepting a commission by men in Priority I, will not, under a new Defense Department ruling effective March 1, 1951, enhance the "Special Registrant's" chances of obtaining a higher rank by lengthening his period of experience.

The new order designed to eliminate inequities changes the method of determining the number of years of experience in qualifying for rank. The new order takes into consideration only the years of experience the Special Registrant had prior to December 6, 1950 (date of pre-induction examination).

**Chiropractors in Indiana**—at the time we meet our deadline—are making strenuous efforts to undermine the Medical Practice Act in Indiana legislature. Among other things, the chiropractors are seeking virtually to nullify the Board of Registration and Examiner's power to procure an injunction.

**Between seventy and seventy-two million** people are now covered by some form of voluntary health insurance, E. L. Henderson, M. D., President of the A.M.A., wrote in the January 27 A.M.A. Journal. Michigan was the first state to go over the two million mark for any one state. New York was the second.

As an example, Dr. A and Dr. B. took pre-induction examinations on the December date—each had 2½ years of experience in practice. Both men were offered commissions as first lieutenants and Dr. A accepted but Dr. B refused. Under the old method, if Dr. B had held out for six months he would be eligible for the rank of captain. Under the new order, only experience before December 6 counts in determining rank.

### **Army Returns 100 Navy Medical Officers**

The first 100 Navy Medical Officers of the 570 physicians that the Navy loaned the Army were due to be returned to the Navy sometime during late February, a release from the Defense Department stated.

The remaining 470 Navy Medical Officers are expected to be ordered back to the Navy in monthly increments. This group was ordered to serve with the Army several months ago when the Army was experiencing an acute shortage of medical talent.

### **Advise Association When Going in Service**

Members in good standing of the Kentucky State Medical Association should notify the Headquarters Office, 620 South Third Street, when going on active duty in the Armed Forces. The Association will waive the annual dues of all members in good standing upon entering the Military, this provision becoming effective at the next billing date for membership dues. The membership fee becomes due on January 1 of each year.

**The establishment of a student loan fund** for the Tennessee State Medical Association was authorized by an action of its Board of Trustees late in November, 1950. The fund would operate much as the Kentucky Rural Scholarship Loan Fund does, and would obligate a debtor to practice in a designated area for at least five years.

**"Chiropractic Challenger"** is the name of a new publication issued by the Committee for Chiropractic Education's national headquarters at Houston, Texas. Proceeds from the weekly paper are to help finance the \$2,500,000 campaign to convey the chiropractic message to the public.



## President's Page

We must remember that physicians who teach and those who engage in research actually are most responsible for the phenomenal progress that our profession has accomplished during the past half century. The majority of discoveries of new medicines and new methods are the accomplishments of research men who spend their entire profession in laboratories, and the testing ground for these processes is generally in our teaching institutions under the direction of those engaged full or part time with students and residents. The intelligent application of these products of research becomes eventually the art and responsibility of the practitioner and they survive or fall into discard as a result of his practical use. Let us avoid the feeling that one part of our profession is more essential than another and share equally and alike in each bit of progress we make. We are truly interdependent.

Our people are the most healthy on earth, not so much because of the curative agents against disease that we have found, not because of our more numerous and better equipped hospitals, nor because we have the largest number of physicians per thousand of population of any country. Sanitation, of all processes, deserves perhaps the greatest credit for our better health. Our efforts for maternal and child health, the control of epidemic and communicable disease including, of course, tuberculosis, and our effective efforts against the spread of venereal diseases follow closely the benefits of sanitation as applied to water, milk, food handler supervision, and sewage disposal. These are all public health measures and correctly under the direction of physicians in this important division of our profession.

The most pressing need just now seems to be not so much in the extension of the activities of public health as in the proper and thorough application of the practices already established. The relative scarcity of physicians and nurses to carry out our

present program in Kentucky is acute and will be difficult to correct perhaps for years to come. Many of our existing county units are severely handicapped by lack of trained personnel and the establishment of new units even when counties have the means to afford them is well nigh impossible. There must always be the closest cooperation of the private physician with the public health activities in his community in order for these efforts to yield the best results, and this is increasingly important now when our health departments are really hard pressed.

The physician in practice may be of material help in a number of ways. First and most important, he must not obstruct or oppose the public health program. This is more important than we may at first glance believe. Many private physicians oppose or lend indifferent support to these activities and greatly influence the public toward this attitude simply because they are prejudiced or actually uninformed or plainly disinterested. The public health physician in any community should be a good salesman. Personal and friendly contact with the practitioners in his county is essential. Participation in the medical society programs and activities of his district is a most helpful medium.

There are, of course, now many localities where for want of a full time health officer or department this work must be carried on part time by a practicing physician and too often receives scant attention and poor direction. This combination of work should be avoided wherever possible. It results in a real subordination of public health to private practice actually and, most unfortunately, in the minds of the people. Public health is too important a function ever to be so subordinated. Properly conducted, the protection against disease and health education en masse is of more far reaching importance than the care and treatment of the individual. It must be a prime concern of all the people and have the support of all physicians if our progress in health is to be maintained.

*Sam A. Overstreet*

PRESIDENT

# County Society Reports

## BATH

The regular monthly meeting of the Bath County Medical Society was held in the office of Dr. D. C. Dotson, Owingsville. Those present were: Drs. D. C. Dotson, Robin A. Byron and B. Ralph Wilson. H. S. Gilmore was absent. The following officers were elected for 1951: Drs. Robin A. Byron, President, D. C. Dotson, Vice-President, B. Ralph Wilson, Secretary and Treasurer, H. S. Gilmore, Board of Censor to serve 2 years, D. C. Dotson, Board of Censors to serve 3 years, B. Ralph Wilson, Delegate to Kentucky State Medical Association, Robin A. Byron, Alternate Delegate to the Kentucky State Medical Association, and Robin A. Byron, Board of Censors one year remaining to serve.

There was discussion concerning the selling of Blue Cross Insurance in Bath county. There being no further business the society adjourned.

B. Ralph Wilson, Secretary.

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## BOYLE

The Boyle County Medical Society met in the dining room of the Ephraim McDowell Memorial Hospital at 7:30 P. M., on the 19th of December. Members present were: Drs. R. G. Jackson, presiding, C. W. Caldwell, B. E. Caywood, J. L. Clay, Milton Davis, Arthur Jester, S. P. Hemphill, C. S. Jackson, B. B. Rader, J. W. Scudder, P. C. Sanders. Dental members were: Drs. E. M. Montgomery and George Davis. Also in joint session with the Boyle County Society were the following members of the Garrard County Society: Drs. V. G. Kinnaid, F. G. Estridge, Warren Harris, and P. J. Sides. Guest member was Dr. E. W. Cook of Centre College.

The program was opened by a travelogue presented by Dr. E. W. Cook, consisting of dozens of Kodachrome slides taken in Venezuela on his biological trip into the jungle. There were numerous interesting pictures of the plant life and scenery along with some interesting photographs of Caracas and other points on his trip to and from South America.

The second paper was presented by Warren Harris, Lancaster, on "The Mechanism of Heart Murmurs." The paper was very instructive, showing the relationship between velocity, viscosity, and diameter of the tube through which a liquid passes to the production of turbidity. Since audible murmurs are dependent on vibration and the loss of energy due to the

production of turbidity in the moving fluid, it was shown that heart murmurs could be produced in a less viscous or anemic blood with a very slight increase in velocity, whereas, the same eddy currents could also be set up by abnormalities in the structure of the openings into and out of heart chambers in blood of normal viscosity. In interpretation of these abnormal vibrations, whether physiologic or pathologic, was then discussed.

Dr. P. C. Sanders gave a report of the Boyle County Health Department's activity since the last meeting and made a plea for more universal immunization of children since there have been five cases of smallpox and two or three cases of diphtheria in the county in the last two months.

The present physician members of the Boyle County Board of Health were nominated and unanimously endorsed. The secretary was instructed to so inform Dr. Bruce Underwood, Secretary, Kentucky State Board of Health.

Dr. Chrisman Jackson was re-elected to represent the Boyle County Medical Society on the Citizens Health Committee.

A plea was made by the Secretary that all delinquent members pay their 1950 A. M. A. dues. A statement of the financial condition of the Society was made and offered for inspection.

Election of new officers was then held. The new officers elected were: Drs. Arthur Jester, President; Charles W. Caldwell, Jr., Secretary and Treasurer; E. M. Montgomery, Dentist, Vice President; the Censor whose term expires in 1953, Dr. C. W. Caldwell; the Delegate to the Kentucky State Medical Society, Dr. R. G. Jackson; and his Alternate, Dr. Arthur Jester.

It is to be noted that the Board of Censors now is: Drs. P. C. Sanders, term expires 1951; S. P. Hemphill, term expires 1952; Charles W. Caldwell, Jr., term expires 1953.

Charles W. Caldwell, Jr., Secretary

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## CALDWELL

At the regular monthly meeting of the Caldwell County Medical Society, January 31, 1951 the following doctors were elected officers for the current year: Drs. B. K. Amos, President, K. L. Barnes, Vice President, W. L. Cash, Secretary, Ralph L. Cash, Delegate to State Association, and Frank P. Giannini, Alternate Delegate.

Pursuant to the request of the Caldwell County Memorial Hospital Board, that the So-



ciety name a representative for membership on the Hospital Board, it was voted that each year this representative should be the incumbent president of the County Medical Society, which makes Dr. B. K. Amos the representative for the current year of 1951.

There being no further business the meeting adjourned.

W. L. Cash, Secretary

### GRANT

The Grant County Medical Society met at the home of Dr. and Mrs. F. R. Scroggin. The President, Dr. C. C. Waldrop presided. Members present were: Drs. R. E. Kinsey, F. R. Scroggin, L. P. Chipman and V. D. Kratz. Guests at the meeting were: Dr. Robert Kratz of Independence, Mrs. R. E. Kinsey, Mrs. F. R. Scroggin and Mr. Everett Chipman.

Officers elected for the year 1951 were as follows: Lenore Patrick Chipman, President, R. E. Kinsey, Vice President, Virginia Daugherty Kratz, Secretary and Treasurer.

The delegate to the state meeting will be Dr. C. C. Waldrop, since he is the outgoing president. The society elected as alternate Dr. F. R. Scroggin.

After the election of officers, Dr. L. P. Chipman presided as President and appointed Dr. F. R. Scroggin and Dr. C. C. Waldrop to the program committee.

The society voted to receive Mr. Paul Harrison, Senior student at the University of Louisville School of Medicine as a member of our society.

The members voted to postpone collection of 1951 dues until more information was obtained regarding the requirement of our members to pay \$25.00 dues for 1950 A. M. A. dues in addition to those to be collected from the State and county members.

The treasurer's report was read and a copy given to each member.

Dr. C. C. Waldrop invited the society to meet with him in January at a place to be announced later.

Before this business meeting just reported, Mrs. Scroggin entertained with a delightful quail dinner.

There being no further business, the meeting adjourned.

Virginia D. Kratz, Secretary.

### HENDERSON

The Henderson County Medical Society held a dinner meeting January 8, 1951 at the Henderson County Country Club. Approximately seventy-five doctors from Southern Indiana

and Western Kentucky attended the meeting.

The guest speaker, Dr. James Barrett Brown, noted plastic surgeon of St. Louis Missouri was introduced by the President, Dr. Walter L. O'Nan and Dr. Elmer J. Rodenberg. His topic was "Management of Tumors of the Face, Mouth and Jaw."

W. Landon Smith, Secretary

### JEFFERSON

The 945th meeting of the Jefferson County Medical Society was held Monday evening, December 18, 1950, at the Seelbach Hotel. Sixty-six members were present for dinner, and about ten additional for the scientific program.

The meeting was called to order at 7:45 p. m., by the President, Dr. J. Andrew Bowen. Minutes of the last meeting were read and approved. The following new members were elected: Drs. Paul M. Crawford, Albro L. Parsons, Active Membership; William B. Deyo, Edsel S. Reed, Associate Membership.

The secretary read a letter from American Cancer Society, regarding three scientific films on cancer available for use by professional groups. The President instructed the secretary to write a letter thanking the Cancer Society for this offer. The secretary read a letter from the Louisville Chamber of Commerce soliciting the cooperation of the Society in inviting the Southeastern Surgical Congress to meet in Louisville in 1952. Motion was made by Dr. R. O. Joplin and seconded by Dr. J. C. Bell and carried to invite this congress.

The secretary read a letter from the Kentucky State Medical Association stating that 30% of the members failed to remit their 1950 A. M. A. dues of \$25.00.

The Scientific program began at 8:00 p. m., with a symposium on Blood Dyscrasias as follows: Urological Manifestations, John M. Townsend, M. D., Gastro-Intestinal Manifestations, Arthur M. Schoen, M. D., Gynecological Manifestations, Glenn W. Bryant, M. D., with discussion by Dr. Marion F. Beard.

The President announced that he had appointed a committee, consisting of Drs. J. R. Buskirk, E. L. Pirkey, and Jesshill Love, to meet with Dr. C. H. Eller's committee to discuss plans for civil defense, after which time they will report back to the Society in detail.

The meeting adjourned at 9:10 p. m.

Robert Lich, Jr., Secretary.

### JOHNSON

The Johnson County Medical Society met January 19, 1951 at the Hotel Herald, Paintsville. We had as our guests the members of the Womens Auxiliary to the Society. After

a delicious steak dinner, the ladies and doctors retired to private rooms for their respective meetings.

The following doctors and their wives were present: Drs. Paul B. Hall, Lon C. Hall, Maurice Hall, D. H. Dorton, Jr., W. E. Akin, John W. Turner; F. M. Picklesimer; A. D. Slone and James W. Archer and Mrs. Lenora Gullett.

The new officers for 1951 were elected as follows: Drs. D. H. Dorton, Jr., President; John W. Turner, Vice-President; A. D. Slone, Secretary-Treasurer.

A discussion was held concerning the holding of the Mobile Cancer Clinic in Paintsville, February 28th, and March 1 and 2nd of this year. It was voted to sponsor this and give it our support.

The Society will again examine the school children of the 1st, 5th, and 9th grades this year as in the past. This will be done at the Johnson County Health Department building starting the first Thursday in February. Each doctor donates an afternoon each week to this work until it is done, along with the Dentists of the city. A charge of two dollars per pupil is charged, but if the pupil is not financially able to pay, he is examined free. The money placed in the treasury of the Society for its work.

During the past year we have made or rather paid for the fitting of glasses for numerous school children and made good donations to the Crippled Children's Society, and the McDowell Home.

The Society wishes to thank Drs. W. E. Walden and H. E. Walden, local optometrists for their support in making glasses for school children who are unable to pay. The Society pays only the cost of materials.

Dr. J. H. Holbrook, retired, was elected member Emeritus. Dr. Holbrook has been a member of the Society from the beginning and has retired because of age and ill health. He suffered a cerebral hemorrhage some weeks ago, but is again able to be out, of which we are thankful.

Dr. W. E. Akin has been ill and is not able to practice at the present, but is able to be out and we welcome him back with us and wish for him a speedy recovery and return to the practice of Medicine and Surgery. Dr. Akin was one of the leading surgeons of the state before his illness.

Augustus D. Slone, Secretary.

#### NICHOLAS

The Nicholas County Medical Society met January 16, 1951 and the following officers were elected for the ensuing year: Drs. B. F. Reynolds, President; T. P. Scott, Secretary;

Jack T. Morford, Delegate; and Marvin E. Johnson, Alternate Delegate.

The following doctors paid their 1950 dues: Drs. B. F. Reynolds, Jack T. Morford, Marvin E. Johnson and T. P. Scott.

Dr. H. H. Buntin is a retired member.

There being no further business, the meeting adjourned.

T. P. Scott, Secretary.

#### SCOTT

The regular monthly meeting of the Scott County Medical Society was held at the John Graves Ford Memorial Hospital on Thursday, January 4, 1951 with the following members present: Drs. W. S. Allphin, L. F. Heath, P. H. Crutchfield, A. F. Smith, D. E. Clark, H. G. Wells, E. C. Barlow, F. W. Wilt and H. V. Johnson.

After the dinner served by the Hospital, the meeting was called to order by the new president, Dr. W. S. Allphin. The minutes of the previous meeting were read and approved.

Dr. F. W. Wilt had charge of the scientific program and gave a case report on a forceps delivery with death of the infant at twenty-four hours; his diagnosis was cerebral hemorrhage.

Mrs. Morris said she had ordered some new records and was adopting a new filing system that would comply with the suggestions of the College of Surgeons.

There being no further business the meeting adjourned.

H. V. Johnson, Secretary.

#### SHELBY-OLDHAM

The Shelby-Oldham Medical Society met at the Stone Inn, Thursday, January 25th with Dr. E. G. McMunn as host.

The following members and guests were present: Drs. H. B. Mack, E. G. Houchin, George Perrine, B. B. Sleadd, L. B. Sternberg, W. P. McKee, Charles E. Allen, A. D. Doak, B. F. Shields, Wyatte Norvelle, E. G. McMunn, H. T. Alexander and C. C. Risk.

The wives of the members attended the dinner and then retired for their meeting. Following the dinner the meeting was called to order by the Vice President, Dr. H. T. Alexander.

Dr. McMunn introduced the speaker of the evening, Dr. Gordon Green, Louisville, who gave a very interesting talk on "Otitis Media."

There being no further business, the meeting adjourned at 9:30 p. m.

C. C. Risk, Secretary.



**WARREN-EDMONSON**

The Warren-Edmonson County Medical Society had its monthly dinner-meeting on December 12, 1950, at the Helm Hotel.

Officers for the year 1951 were elected. Colonel R. A. Radke of Fort Knox gave a most interesting paper on Amebiasis, and Dr. Robert O'Connor, Louisville, spoke on Psychosomatic Problems in General Practice. About twenty-five doctors were in attendance.

Frank H. Moore, Secretary.

**WARREN-EDMONSON-BUTLER**

The Warren-Edmonson-Butler County Medical Society met at 7:30 P. M., on January 9, 1951 at the Helm Hotel for its customary dinner meeting. It was decided that the next meeting should be dedicated to honor Dr. G. H. Freeman, who is celebrating his fiftieth year in practice. A committee for arrangements was appointed.

Dr. John R. Glover, Nashville, Tennessee, discussed, "Disorders of the Hip Joint," in a very scientific and interesting manner, using movies and lantern slides.

Approximately fifteen members were in attendance. Dr. Ernest Rau was made an honorary member.

There being no further business the meeting adjourned.

Frank H. Moore, Secretary.

**WEBSTER**

At a meeting held by the physicians in Webster county for the organization of the Webster County Medical Society Dr. J. E. Jenkins moved that Dr. Russell A. Scott be elected President, the motion was seconded by Dr. E. W. Atherton. Motion carried.

It was moved and seconded by Dr. M. M. Davis and Dr. W. W. Wainer that Dr. E. W. Atherton be elected secretary. Motion carried.

Dr. W. W. Wainer was appointed by Dr. R. A. Scott as delegate to the Kentucky State Medical Association meeting.

Dr. E. W. Atherton was appointed by the president to investigate and report on proper dues scale for the society.

E. W. Atherton, Secretary.

## News Items



**CARL NORFLEET, M. D.**

**Somerset**

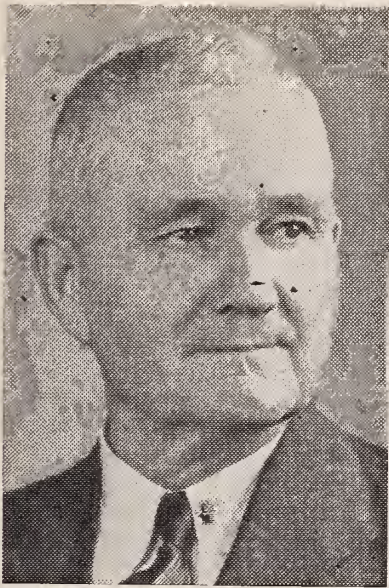
Dr. Norfleet has served in the following capacities in our organization: Past President, Pulaski County Medical Society, Secretary Pulaski County Medical Society, Medical Referee for Pulaski County for more than twenty-five years, Member of Pulaski County Board

of Health for more than thirty years, Director Pulaski County Health Unit since May 1948, Member of House of Delegates for many years, Trustee Medical Scholarship Fund since its establishment.

Other capacities Dr. Norfleet has served: Manager and Surgeon, Somerset General Hospital, for twelve years, Chief of Staff of the new Somerset City Hospital, 1946.

Drs. Sidney Evans Johnson and Jesshill Love announce the association of Dr. Edward Nisbet Maxwell in the practice of Radiology at St. Joseph Infirmary, Louisville. Dr. Maxwell was graduated from the Medical College of Virginia in 1944 and served his internship at the Marine Hospital, New Orleans, Louisiana from October 1944 to July 1945. After two years of military service he served a three year residency in Radiology at St. Joseph Infirmary, Louisville, completing this in July 1950.

The physicians of Logan County are furnishing the doctors' library at the new Logan County Hospital. To mark the completion of the new building an open house and program was held December 31st in the high school auditorium and was followed by a reception at the hospital.



W. L. CASH, M. D.

**Princeton**

Dr. W. L. Cash, former mayor of Princeton, received the 1950 Kiwanis Cup Award for outstanding citizenship. Dr. Cash was born in Caldwell county and was graduated from the University of Louisville Medical Department, Louisville in 1907. During the more than forty-three years since, his service has known the horse which he rented from the livery stable, the farmer's mule which met him at the road's end, and the willing footsteps which carried him where no trail could be discerned, and he has been the attending physician at approximately 2,500 births. For thirty consecutive years he has been secretary of the Caldwell County Medical Society also serving as President. He was for nine years secretary of the Four County Medico-Dental Society.

In 1913 he was appointed Health Officer for Princeton; County Health Officer in Caldwell from 1917-1920; Vice-President of the Kentucky State Medical Association in 1948; Vice-President of the Southwestern Kentucky Medical Society in 1929; Director of the Caldwell County Health Unit since 1942, member of the Caldwell County Board of Health for fifteen years; member of the Kentucky Academy of General Practice; and many times a delegate to meetings of the Kentucky State Medical Association.

In 1948 Dr. Cash was a delegate from the State to the National Democratic Convention in Philadelphia. For eight years he served as executive chairman of the Democratic Party in Caldwell County, 1940-48. He was chairman of the Caldwell County Red Cross for twelve years, 1933-1945.

At the Kentucky branch, American College of Physicians which met in Lexington, Saturday, December 9th, the following local doctors were on the program: Drs. R. C. Blount, T. G. Hobbs, Thornton Scott, Allen L. Cornish and F. B. Moosnick.

The banquet held at the close of the conference was presided over by Dr. Charles N. Kavanaugh, Lexington, and Dr. J. M. Kinsman, Louisville, was toastmaster.

The Sisters of Charity of Nazareth were hostess to their Staff Doctors at a banquet at Marymount Hospital, London. A gratifying addition to the Staff's convenience is a medical Library recently constructed at the hospital. A room set aside on the main floor has proven to be not only attractive, but a great asset to the doctors interested in the latest procedures and techniques in the Medical profession.

Louisville's five cancer clinics have been approved by the American College of Surgeons. The clinics are located at General Hospital, Norton Memorial Infirmary, St. Joseph Infirmary, Red Cross Hospital, Louisville, and Central State Hospital at Lakeland. The College also approved eight other Kentucky clinics.

In the December 11th issue of the Time Magazine there appeared a very interesting article about Dr. D. G. Miller, Jr., of Morgantown. This article explains how Dr. Miller and his wife, who is a registered nurse, alleviated the obstetrical problems in a rural district by equipping two rooms in their office, one for the labor room, the other for the actual delivery.

November 5-8, 1951 are the dates selected for the forty-fifth annual meeting of the Southern Medical Association, which will be held in Dallas, Texas. The Dallas meeting will emphasize the fact that the Southern Medical Association meeting is the outstanding medical meeting of the year.

Graduates from approved medical schools in 1950 were 5,533 physicians, an increase of 459 over 1949. This was the largest number of graduates in any one year except for 1946 and 1947, when several schools at the end of their wartime program graduated more than one class during a 12 month period.





ALEX J. STEIGMAN, M. D.

Louisville

Dr. Alex J. Steigman, Professor of Child Health in the new Child Health Laboratory, University of Louisville School of Medicine will initiate poliomyelitis research. Mr. Eli Brown, III, Acting President, University of Louisville, announced that Dr. Steigman had been given \$7,700 by the National Foundation for Infantile Paralysis for this purpose. This is the first such grant ever made to an institution in Kentucky.

## *In Memoriam*

JOHN MAXWELL RYAN, M. D.

Carrollton

1892 - 1950

Dr. John Maxwell Ryan, Carrollton, died December 17, 1950. Dr. Ryan had been a practicing physician in Carrollton for the past thirty years. He was born in Vevay, Indiana in 1892 and was a graduate of the University of Louisville School of Medicine in 1917. He served his internship at the Louisville City Hospital. A veteran of World War I, he served in the Medical Division in the Army. Dr. Ryan did so much for his community during the four war years that he was given the "Citizenship Award of the Year" by the Carrollton Chamber of Commerce on January 25, 1946.

JOHN HENRY HARRALSON, M. D.

Central City

1890 - 1951

Dr. John Henry Harralson, prominent Central City and Muhlenberg County physician, died January 27, 1951 from a heart attack.

Dr. Harralson was born near Nebo, Hopkins County in 1890. He was a graduate of the University of Louisville Medical Department in 1915. During World War I. he served for two years with the British Army. He practiced at Mortons Gap, Hopkins County and Graham, Muhlenberg County until 1930 when he moved to Central City.

## BOOK REVIEWS

**THE SCIENCE OF HEALTH** by Florence L. Meredith, B.Sc., M. D., Fellow of the American Medical, American Public Health, and American Psychiatric Associations. Second Edition. 1951. The Blakiston Company, Philadelphia. 48 Tables and Charts; 134 Illustrations; 452 Pages. Price \$3.75.

A new edition of this well-known text for a college health and hygiene course is brought completely up-to-date with many simplified and diagrammatic illustrations and new material on contemporary subjects.

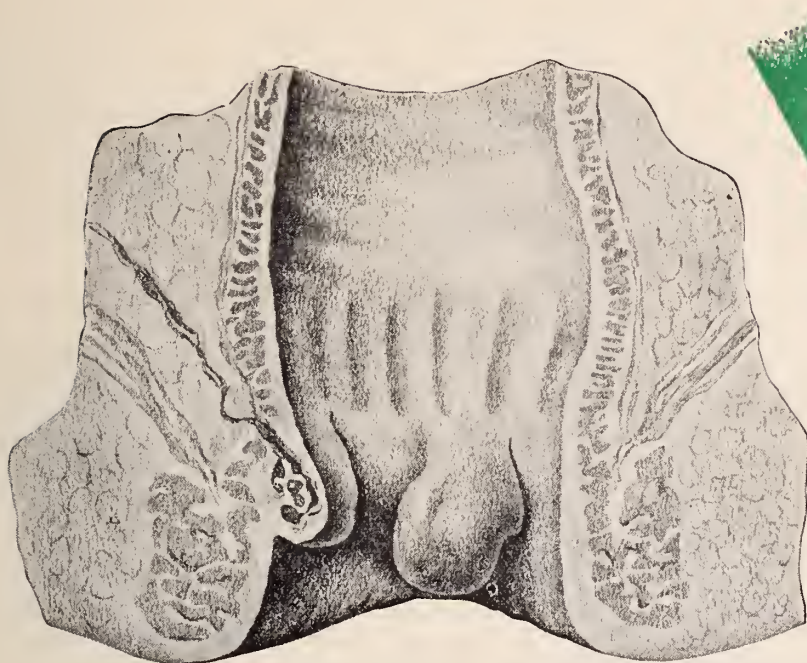
The features include the expanded sections on vitamins and antibiotics, and current statistics on height, weight, age averages, the leading causes of death, and similar material presented in charts, tables and appendices.

The mental health section contains an outstanding introductory discussion on the psychology of adjustment.

The text's readable and interesting style gives the student a clear picture of the fundamentals of personal, physical and mental health, and helps him to understand the health problems of many people today.

**PHYSICAL DIAGNOSIS (Fourth Edition)** by Ralph H. Major, M. D., Professor of Medicine in the University of Kansas. 446 pages with 469 figures. Philadelphia and London: W. B. Saunders Company. 1951. Price \$6.50.

This book is a summary of fifteen years' experience in teaching diagnosis to medical students. The author has emphasized, as Skoda did a century ago, that physical signs are produced by physical causes, and that those underlying physical causes must be understood before the physical signs can be properly appreciated.



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He has deliberately avoided any chapters on roentgenology, electrocardiography, urine, feces, etc., for two reasons. First, this is a textbook of physical diagnosis, and second, these other subjects are far better presented in books written by experts in these fields. When roentgenograms, electrocardiograms or pulse tracings are employed they are used only to make certain explanations clearer.

The author has made free use of quotations, partly because of an interest in classic descriptions, and partly because of the excellence of many of these early accounts, and in many instances, employed the illustrations used by the pioneers in certain fields of investigation, thinking for instance that Traube's original curve of pulsus alternans is of more interest than any of the thousands of curves of this condition which have been made since.

The review of the descriptions of the older masters is interesting so says Osler "And when you can, read the original description of the masters who, with crude methods of study, saw so clearly." Also, since the descriptions of Biot's breathing, of Traube's semilunar space, of Skoda's resonance, and of other physical findings vary in different books, it is of interest to see what these men themselves wrote on these subjects.

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**PAUL EHRLICH**, by Martha Marquardt, with an introduction by Sir Henry Dale; 255 pages with illustrations. Publishers, Henry Schuman, Inc., 20 East 70th Street, New York. Price \$3.50.

This biography is fascinating as an account of the great strides forward in the medical laboratory. It is also an absorbing picture of a dedicated and inspiring human being. Readers will admire Ehrlich for his wonderfully human qualities as well as for what his research and ideas have done for science and mankind. His whole existence was one long fight for the promotion of medical science in the service of mankind. He had deep rooted, unwavering optimism, aiming always at perfection in ever more difficult projects, inspired always by an unshakable faith in progress.

The author, Martha Marquardt, was Ehrlich's secretary for 13 years. In this first full-length biography in English, she gives a fascinating account of his working life in which she was closely associated, and a lively personal portrait of Paul Ehrlich's complex character—his tenacity, his brilliant and prophetic imagination, his remarkable vision.

Paul Ehrlich's laboratory was a mecca which no medical scientist would fail to visit when

in Europe. In it he discovered Salvasan (606) the famous Magic Bullet, the first specific and radically effective cure for syphilis. It was there that Ehrlich established the new science of chemotherapy, the treatment of diseases with synthetic chemicals created in the laboratory. His pioneering work in this field led eventually to the sulfa drugs, led Florey and his team to examine anew the half-forgotten penicillin, inspired the discovery of streptomycin.

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**A TEXTBOOK OF X-RAY DIAGNOSIS** by British Authors in Four Volumes. Second Edition. Edited by: S. Cochrane Shanks, M. D., F. R. C. P., F. F. R., Director, X-Ray Diagnostic Department, University College Hospital, London; and Peter Kerley, M. D., F. R. C. P., F. F. R., D. M. R. E., Director, X-Ray Department, Westminster Hospital; Radiologist, Royal Chest Hospital, London. Volume IV. 592 pages, 553 illustrations. Philadelphia and London: W. B. Saunders Company, 1950. Price \$15.00. Publisher.

The New Second Edition is being published in four volumes, and the volume on Bones, Joints and Soft Tissues is now available to the medical profession. The other three volumes will be released in the near future. In 592 pages and 533 illustrations this book covers adequately all common lesions of the bones, joints and soft tissues, with the material subdivided into eleven parts as follows: Bones and Joints; The General Pathology of Bone; Congenital Deformities of Bones and Joints; Inflammatory Diseases of Bones and Joints; Osteochondritis; Static and Paralytic Lesions; the Intervertebral Discs, Orthopedic Operations; Constitutional Disease of Bones and Joints; Tumors and Cysts; the Soft Tissues; and Localization of Foreign Bodies.

The X-ray illustrations are brilliantly produced; the accompanying text is clear, concise, and highly informative. This is a valuable book for the surgeon, technicians and others interested in this field of work. It is not an overstatement to say this great work is one of the most widely circulated editions on this subject.

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**TECHNIQUES IN BRITISH SURGERY**, by Rodney Maingot, F. R. C. S. England, Surgeon, Royal Free Hospital, London; Senior Surgeon, Southend General Hospital. Illustrated. 734 pages, with 473 figures. Publisher: W. B. Saunders, Philadelphia. Price \$15.00.

The Board of Trustees of the American Medical Association has approved a plan to exchange physicians between Great Britain and

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the United States, and Maingot's book will be welcomed by the physicians in this country as they will become familiar with the technique of our brilliant brothers across the sea. The contributors, all of whom are in active practice and accomplished teachers, have been asked to draw mainly from their own experience and to present their subjects in their own manner with special emphasis on technique. The articles are representative of the best this country can show.

29 topflight British surgeons were invited to contribute to this book, detailed accounts of the operative techniques they have perfected, techniques that are acknowledged to be the most effective known in Great Britain at the present time.

While step by step procedure is emphasized (and demonstrated in more than 1,000 pictures on 473 figures) a well balanced amount of attention is paid to pre and postoperative care, prevention and treatment of complications, and general management of the case. General and special surgeons, practitioners and many specialists will find this new volume a real storehouse of thoughts, hints, helps and ideas that can be applied in whole or in part to their own practices.

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**SEXUAL FEAR** by Edwin W. Hirsch, B. S., M. D. Attending Urologist, Englewood Hospital, Chicago, Illinois; former Associate in Urology, College of Medicine, University of Illinois; Member A. M. A., American Urological Society. Publishers: Garden City Publishing Company, Inc., Garden City, New York. Price \$3.00. 1950.

The subject of sex is equally interesting to the physician as it is to laity. This book gives a compilation of sex life of many of the ancient civilizations and brings the subject up to the present time with a great insight into problems involved and the advice given is good for the physician to have so he can be able to advise his patients scientifically how to overcome sex fear and its concomitant results.

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**TEXTBOOK OF ENDOCRINOLOGY:** Edited by Robert H. Williams, M. D., Executive Officer and Professor of Medicine, University of Washington Medical School, Seattle. With the collaboration of: Peter H. Forsham, Harry B. Friedgood, John Eager Howard, Edwin J. Kepler, William Locke, L. Harry Newburgh, Edward C. Reifenstein, Jr., William W. Scott, George Van S. Smith, George W. Thorn, Lawson Wilkins. 793 pages with 168 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price \$10.00.

This new book provides very useful information on endocrinology and it represents the

contributions of 11 outstanding authorities on the subject. It covers all clinical aspects of both male and female endocrinology. Not only does it give the new treatments, but it is based on today's fuller understanding of the methods by which hormones influence body function.

It also represents an understandable, authoritative guidance on how to recognize and treat endocrinopathies resulting from dysfunction of the pituitary, thyroid, adrenals, testes, ovaries, pancreas, and parathyroids.

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**WORLD SURGERY** Edited by Stephen A. Ziemman, M. S., M. D., F. A. C. S., F. I. C. S. Formerly: Assistant Editor, U. S. Navy Medical Bulletin. J. B. Lippincott Company, E. Washington Square, Philadelphia 5, Pa., Publishers. Price \$6.00.

This volume contains a wealth of useful material carefully selected from the world's leading surgical journals. Ideas, technics, improvisations, emergency procedures have been skillfully condensed and translated. Practical technics and procedures, methods useful in the surgeon's everyday practice are emphasized.

Wherever technical detail is needed to bring out these aspects, technical details will be found. The author has given many case reports, each accompanied by its authentic source. Those who desire to make a fuller study of any particular case will find the references complete and ready to hand.

World Surgery is organized in ten sections, covering the major fields of surgery. The text is well illustrated throughout.

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**THE MERCK MANUAL OF DIAGNOSIS AND THERAPY,** a Source of Ready Reference for the Physician. Eighth Edition. Publisher: Merck & Company, Rahway, New Jersey. Price: Regular edition \$4.50; Thumb-Index \$5.00.

More than 100 clinicians throughout the United States have served as authors or consultants in this new eighth edition. The general content includes 1,600 pages with 338 chapters in Part I on the diagnosis and treatment of disease, and nearly 2,000 prescriptions are included and arranged according to therapeutic action. Part II is devoted to immunization, clinical and bedside procedures, laboratory tests, and experiences in World War II. The antibiotic therapy has been gone into in detail and the treatment with crystalline Vitamin B<sub>12</sub> is covered in the chapters on megaloblastic anemia and sprue.

This book is a very convenient model and will be an ornament to the physician's desk, and especially valuable as it is arranged with thumb index and printed on thin, oxford paper.

# The JOURNAL of the Kentucky State Medical Association

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NO. 4

## VAGOTOMY AND PYLOROPLASTY THE PHYSIOLOGIC TREATMENT FOR DUODENAL ULCER

Howard E. Dorton, M. D., F. A. C. S.

and

Jack Graham Webb, M. D.

LEXINGTON

Most patients with duodenal ulcer can be managed quite satisfactorily by means of medical measures. Only 10 to 15 per cent ever need be considered for surgery<sup>1</sup>.

Until Dragstedt's<sup>2</sup> revival of vagotomy, gastric resection was the operation of choice in these cases. We have no argument with those who still adhere to gastric resection. It has been perfected to the point where in the larger centers it has an acceptable mortality rate (2-3 per cent)<sup>3-4</sup>. During 1947, 1948 and 1949, eighty-two partial gastrectomies were performed by Lexington surgeons for relief of duodenal ulcer. The mortality rate was 2.5 per cent. Gastric resection gives good results in about 90 per cent of the cases. (Walters<sup>5</sup>, 83.5 per cent of 197 patients; Allen and Welch<sup>6</sup>, 93 per cent of 1290 patients).

It is well known, however, that gastric resection for duodenal ulcer carries a definite risk of *permanent morbidity*. For example, out of every hundred such resections performed by experienced surgeons two or three will die; ten or fifteen will develop acute gastric retention, (for which a few will require immediate re-operation); six to eleven will develop marginal ulcers, one of which will perforate into the colon; bleeding will recur in one out

of four; the dumping syndrome will occur in five or seven; and practically all will consistently fail to gain weight. This *permanent morbidity* has led us to make a clinical trial of a much less serious procedure which, to date, in our hands, has none of the above mentioned morbidity. This procedure is vagotomy combined with pyloroplasty.

### Percentage of Cures

Vagotomy alone has been found by Ruffin<sup>7</sup> to cure 85-90 per cent of ulcers. Most of the unsatisfactory results were not found to be due to ulcer recurrence but were caused by gastric retention secondary to relative pyloric obstruction. This obstruction resulted in fermentation of gastric contents with foul eructations and bouts of diarrhea.

Because of these difficulties with emptying following vagotomy alone Gardner and Hart<sup>8</sup> found that 12 per cent of their patients required a secondary drainage operation. Dragstedt and Camp<sup>9</sup> have concluded that from 20-25 per cent of all nerve operations should have a simultaneous drainage procedure to obviate retention and its associated disagreeable sequelae. Most frequently the combined procedure has been vagotomy and gastro-enterostomy although some have mentioned pyloroplasty as an alternative<sup>10</sup>. Results to date on a combined



procedure have been encouraging. Crile<sup>10</sup> recently reported on two groups of patients with duodenal ulcer who were treated at the Cleveland Clinic and traced for a period of eighteen months each. He found the results generally better in that group of eighty-seven patients who were treated by vagotomy and a drainage operation, as compared with the group of eighty-seven patients who were treated by gastric resection or gastro-enterostomy alone. He did not indicate a preference for any particular type of drainage procedure except to state that gastro-enterostomy was the more frequent drainage procedure employed. He does state that there was no significant difference in the results following vagotomy and gastro-enterostomy as compared with vagotomy and pyloroplasty.

### Pyloroplasty

In view of the above, and since pylorospasm is considered by many to be one of the contributing factors in the production or perpetuation of duodenal ulcer, we have focused our attention upon elimi-

nation of this factor. Pyloroplasty also permits direct inspection of the ulcer. In addition to confirming the existence of an ulcer, this approach can also be used to control an actively bleeding vessel and has been done on three occasions in this series (fig. 1). In suitable cases where the ulcer is located anteriorly the scarred unhealthy area can be completely removed. The remaining healthy mucosa should be more resistant to subsequent ulceration than a scarred area if the ulcer is left to heal spontaneously. Posterior ulcerations have been left untouched and to date have healed without incident. Pyloroplasty has the further advantage that the proximity and reflux of the alkaline duodenal content is not disturbed as it is with gastro-enterostomy, particularly the long loop variety. Since using pyloroplasty we have not had a case of acute gastric retention. Pyloroplasty also prevents stricturing at the outlet of the stomach as the ulcer heals. Another advantage aside from the simplicity of its performance (fig. 1) is the fact that it does not alter the anatomic arrangement of the stomach. This should be of considerable help if at a future date gastric resection should become necessary either for recurrent ulcer or carcinoma (See case report 2). Resection of a stomach having marginal ulceration of a gastroenteric stoma presents considerable in the way of technical difficulty and carries higher operative risk than primary resection. We feel that recurrence of duodenal ulcer following vagotomy and pyloroplasty will be rare and will be no more serious in its surgical implications than would recurrence following a "cure" on medical management. Finally, we felt that pyloroplasty, in itself, was much less likely than gastro-enterostomy to cure a patient of ulcer. It is well known that gastro-enterostomy alone will cure between 70 and 80 per cent of ulcers<sup>1</sup>. Therefore, it was felt that our results would be less clouded if we used pyloroplasty since when used alone it cures only about 20 per cent of ulcers.

Since selection of vagotomy and pyloroplasty as being in our opinion the most rational approach to the problem we have used the combination on twenty-two patients with duodenal ulceration, proven at operation. The factual data concerning these patients is shown in table 1.

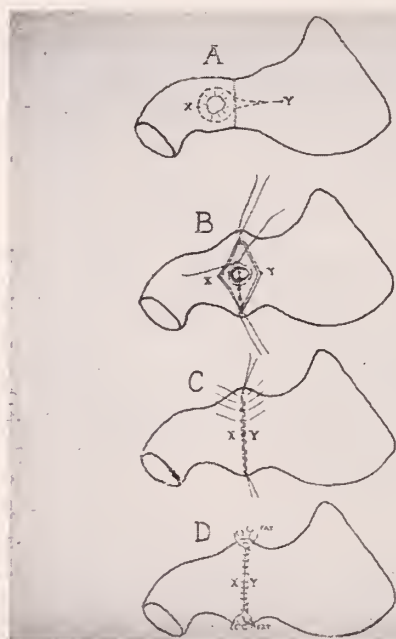


Figure 1. Pyloroplasty.

- A. Line of excision of anterior wall ulcer to avoid running unnecessarily far down on the relatively thin walled duodenum.
- B. Mattress suture placed to control bleeding posterior wall ulcer.
- C, D. Method of closure inverting a minimum of tissue.

Table I  
Data on 22 patients with Duodenal Ulcer treated by means of Abdominal Vagotomy and Pyloroplasty

Date of Operation	Age	Sex	Symptoms				Hosp. Days	No. of Vagus Branches	Result
			Duration-Yrs.	Obstruction	Bleeding	Perforation			
1. G. DeC...15 May 47	32	M	15	-	-	-	8	6	Satisfactory*
2. J. T.... 3 Sept. 47	48	M	12	/	(/)	-	7	2	Excellent
3. B. B....18 Oct. 47	51	F	15	/	/	-	7	5	Excellent
4. I. A.... 2 Feb. 48	42	M	10	/	-	-	7	2	Excellent
5. L. M....14 Feb. 48	50	F	1	-	-	-	7	3	Excellent
6. S. S....23 Feb. 48	39	M	10	/	/	-	7	2	Excellent
7. B. C....30 June 48	42	M	12	/	/	-	6	4	Excellent
8. J. H.... 9 Aug. 48	36	M	20	/	-	-	6	2	Excellent
9. S. S....12 Aug. 48	47	M	20	/	-	-	6	2	Excellent
10. A. C.... 7 Feb. 49	45	M	20	-	-	-	6	5	Excellent
11. J. D.... 9 Feb. 49	49	M	9	-	-	/	6	2	Excellent
12. T. N....29 Apr. 49	36	M	10	-	(/)	-	7	12	Excellent
13. A. W....30 Apr. 49	21	F	3	-	-	-	6	4	Excellent
14. J. L.... 6 June 49	27	M	4	-	-	-	6	4	Excellent
15. H. N.... 7 June 49	25	M	3	-	-	-	6	3	Excellent
16. F. A....25 June 49	38	F	3	/	/	-	6	2	Excellent
17. G. F....20 Sept. 49	24	F	4	/	/	-	6	4	Fair, no recur**
18. C. H....26 Jan. 50	50	M	15	-	-	-	6	2	Excellent
19. J. Mc...13 Feb. 50	46	M	7	/	-	-	6	2	Excellent
20. H. A....20 Feb. 50	26	M	5	-	-	-	6	2	Excellent
21. S. C.... 4 Apr. 50	28	M	3	-	(/)	-	7	6	Excellent
22. R. P.... 1 Mar. 50	40	M	9	-	-	/	6	6	Excellent
Totals			5 F 17 M	9.5 yrs.	9	(5 severe)	2	6.4	

(/) Operated upon during hospitalization for severe bleeding.  
\* See Case Report No. 1.  
\*\* See Case Report No. 2.

Operative Technique

Endotracheal gas-oxygen-ether anesthesia is used. The abdomen is entered through an ample rectus muscle splitting incision extending from the left xiphocostal angle down to about an inch below and an inch to the left of the umbilicus. The left lobe of the liver is detached from the diaphragm and reflected toward the patient's right. The esophagus is exposed by blunt dissection with the fingers and a soft rubber tissue fillet is placed around it for gentle traction. The vagus nerves are located by palpation and inspection. Their inelasticity as compared with esophageal resiliancy makes their identification relatively easy. The nerves are divided and ligated with medium silk to prevent their regeneration. The numbers of branches found are shown in table 2. As can be seen from this table, less than half of our patients had only two main vagus

Table 2  
Number of Vagus Nerve Branches Found at Operation in 22 Patients with Duodenal Ulcer.

Number of Branches	Number of Patients
2	10
3	2
4	4
5	2
6	3
12	1

trunks, whereas Walters<sup>11</sup> and others have reported that in 92 per cent of patients two trunks only were found. Most of the remaining twelve patients did have two large trunks, but in addition, had several smaller branches. In several instances, we found small and large trunks in the retro-esophageal areolar tissue which had been left behind in freeing up the esophagus. We are convinced that it is failure to recognize and divide these branches that is the cause of the reported cases of failure following vagotomy.

Following the vagotomy a Heinicke-Mikulicz or Judd pyloroplasty is performed as shown in fig. 1. Wherever practicable the ulcer is excised. The transverse closure is done inverting just as small an amount of tissue as is consistent with a good closure. We use two rows of continuous chromicized gut sutures and reinforce this with a row of interrupted black silk sutures. We feel that a rough closure might obstruct or leak or later on be a weak point more subject to ulceration. Appendectomy was performed in five cases where it was felt that it would not add appreciably to the operative risk. One Meckel's diverticulum was found and removed. Incidentally, this contained ulcerated gastric mucosa.

Post-operatively continuous nasogastric suction was utilized as advocated by Meyer and Stein<sup>12</sup> and oral intake was



prohibited until normal peristalsis was resumed. Passage of flatus was used as the criterion for removal of the suction tube and resumption of oral intake. This occurred without exception by the third or fourth post-operative day. Tap water was then given in graduated small doses during the next twenty-four hours. If well tolerated this was followed by six small bland feedings daily. The patient was instructed to recline and turn on his right side following each feeding with the idea that this might promote more efficient emptying of the temporarily atonic stomach. The nature and duration of the gastric atony associated with the procedure was carefully explained to each patient so that complete cooperation could be obtained to avoid overloading the stomach during the ensuing few weeks.

### Prognosis

On this program these patients were out of bed on the second post-operative day, started on water on the third or fourth day, given food on the fifth day and dismissed from the hospital on the sixth day. Aside from two cases of transient right lower lobe atelectasis there were no complications. Resumption of three regular meals was accomplished in from three to six weeks. After the temporary recurrence noted in case 1, all patients were advised regarding the direct action of alcohol, nicotine, and caffeine upon the gastric glands and were advised to use these items cautiously and preferably upon a full stomach when there would be food available to neutralize the extra acid thus called forth.

### Results

There were no operative deaths. The average hospital stay was 6.4 days. This is certainly a great advantage over gastric resection, the average hospital stay in Lexington in these cases being nearly two weeks. All twenty-two of these patients have been followed closely since operation. In order to obtain uniform information for this report they were each furnished a questionnaire (fig. 2). Seventeen of these patients have gone an average of eighteen months, the longest post-operative duration being thirty-nine months. While this is not a long follow-up, the results have been so satisfactory to date that we feel they are worth reporting.

Only two patients (cases 1, 17) complained of any type of recurrent pain.

1. Have you had any of the same old pain since your operation? No  
If so, how much, what brought it on, and what relieved it? \_\_\_\_\_

2. Aside from the pain of the wound of your abdominal incision, have you had any other type of abdominal pain? No. Please describe. \_\_\_\_\_

3. How is your appetite? Excellent. Can you eat anything you want? Yes. What can't you eat? \_\_\_\_\_  
Does tea, coffee, or alcohol bother you? No. How much at one time before you're done? \_\_\_\_\_

4. Do you have any trouble swallowing? Occasionally. Does food seem to enter anywhere? Low in throat or high in chest - Occasionally

5. Have you been bothered with an unusual amount of gas or flatulence and belching? No. If so, how long did it last? \_\_\_\_\_

6. Have you wanted to spit just a time or two? No. What came out? Thin. Did it taste like your water, or cold, or milk? Good. Was it yellow or green? Yellow

7. Have you noticed any blood? No. Have you noticed any blood or tarry-black bowel movements? No

8. Has there been any change in your bowel habits? No. Back to normal? Yes. Constipation? No. Diarrhea? No. If you have had diarrhea was it troublesome? \_\_\_\_\_ or just temporary? \_\_\_\_\_

9. Have you lost weight or gained weight? Gained. How much? 35 lbs.

10. How is your general health? Excellent

11. Indicate from the way you live in your home or in your hospital to friends or relative with an ulcer? By all means, yes.

12. Remarks....  
*Have been highly pleased with operation, and have recommended it to everyone I can.*

Figure 2.

Copy of questionnaire used in follow-up of patients. Response from Case No. 7 which is representative of all but one of these 22 cases reported.

These are discussed in detail in the appended case reports. All have reported having good appetites. Only three patients have any sort of dietary restrictions and these are for greasy foods in one instance, oysters in another, and corn and beans in another. They had been unable to tolerate these foods pre-operatively. One patient felt that coffee and tobacco definitely hurt him (case 1). Two patients had mild transitory dysphagia stating that it felt as though food would stick behind the lower sternum.

### Symptoms

The most common symptom reported was flatulence which was mild and transient in seven patients and moderate and transient in another. Vomiting occurred a few times post-operatively in four patients and cleared up satisfactorily. The vomitus in two cases was reported as tasting like warm water and in the other two cases, like gall. None of the patients had any evidence of post-operative bleeding although nine had had bleeding pre-operatively, and three of these were operated upon during hospitalization for severe hemorrhage. Bowel habits were uniformly improved probably secondary to resumption of a better diet. Three patients had transient diarrhea of three to

four stools a day. One patient had three to four stools daily for about a week. This was satisfactorily controlled by a single short course of sulfasuxidine. Two remained slightly constipated. All, except three, of the series reported their general health as being excellent or "better than ever before." Three stated that their general health was "fair." Ten of these patients gained an average of 23.3 pounds. Eleven maintained their pre-operative weight. Only one patient lost weight and this amounted to only three pounds. This is in direct contradistinction to the reaction of gastrectomy patients who consistently fail to gain or actually lose weight.

Twenty-one of these patients were well satisfied with the results of their operation to date and stated that they would heartily recommend it. The other patient upon whom we performed a subsequent gastric resection, and did not find an ulcer, is completely well to date.

### Case Reports

Case No. 1: Mr. G. DeC., age 32, fifteen year ulcer history.

On May 15, 1947 a vagotomy and pyloroplasty was performed. He was completely relieved until July 29, 1949, twenty-six months later, when his old ulcer symptoms returned. X-ray showed a duodenal ulcer with crater. The stomach emptied normally in spite of very little evidence of peristalsis. At this point the patient volunteered the information that due to unusual business stress he had, for the two weeks preceding the recurrence, subsisted almost exclusively on black coffee and cigarettes. During this same period he "had not eaten more than enough to make up one good meal."

Accordingly, the direct action of caffeine and nicotine upon the gastric secretory mechanism<sup>13</sup> was explained to him and he was asked to cooperate in an experiment. The only restriction placed upon him was to forbid the use of coffee and tobacco. He was advised to eat three regular meals daily, the food to be of his own choosing. On this regimen, within two days the pain had subsided completely. Four weeks later X-ray showed the ulcer to be healed. He has remained well since. We feel certain that such a recurrence could be produced following either vagotomy or resection in a large per cent of cases if they were fed this bizarre "diet."

Case No. 2: A 24-year old white female with four year ulcer history, includ-

ing frequent vomiting and one episode of moderate bleeding. On September 20, 1949 a vagotomy and pyloroplasty was performed for an anterior wall ulcer. Convalescence was uneventful. On October 8, 1949 she began vomiting small amounts immediately after eating. An X-ray showed no obstruction or ulceration. At this time psychogenic vomiting was suspected and she was placed on mild sedation and antispasmodics. The vomiting continued off and on until February 1950 when she began to have some vague back pain centering over the right renal area. Repeat stomach X-ray on March 6, 1950 was reported as showing a markedly deformed duodenal cap and a chronic perforation along the inferior border of the first portion of the duodenum. Because of the X-ray findings it was thought best to re-operate. Accordingly, on March 14, 1950 a subtotal gastric resection was performed although there was no gross evidence of perforating ulcer or obstruction present. The specimen showed the pyloroplasty to be well healed and there was no evidence of ulceration (fig. 3). The pyloric stoma easily admitted a thumb and was soft and pliable. There were two small "dog ears" at the upper and lower angles of the py-

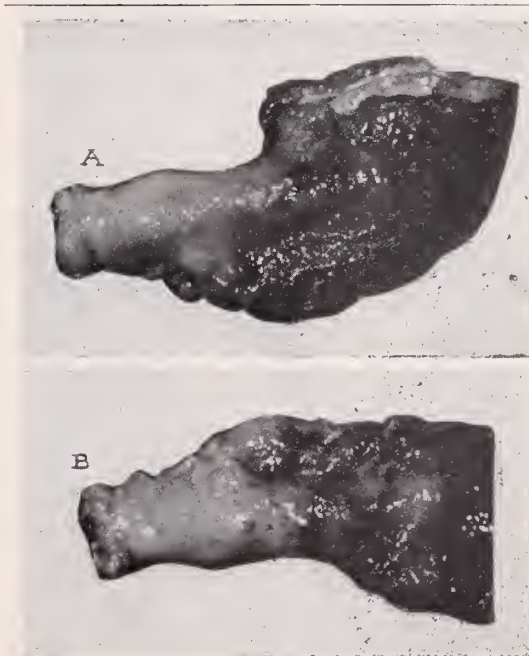


Figure 3.

Case 17. Partial gastrectomy specimen turned inside out to demonstrate wide open pyloric outlet and lack of ulceration. See fig. 4 which shows pseudo perforation which led to operation.



loroplasty which probably accounts for the X-ray appearance of penetrating ulcer (fig. 4). In the future we will not reoperate this type of patient on X-ray findings alone but will depend more upon the history and physical findings.

### Summary

1. Eighty-five to ninety per cent of patients with duodenal ulcer can be managed satisfactorily by means of medical measures.

2. In intractable or complicated cases gastric resection is the procedure proven by time to yield about 90 per cent good results. However, the mutilating nature of the procedure, together with its magnitude, risk (2-3 per cent mortality), and definite production of 5-10 per cent of marginal ulceration, we feel, justifies a



Figure 4.

Case 17. Vagotomy and pyloroplasty September 1949. X-ray March 1950 shows what was thought to be a perforating ulcer. See specimen in fig. 3.

search for a simpler, safer and more satisfactory procedure.

3. In vagotomy combined with pyloroplasty we feel that we have found such an improved procedure.

4. We have selected pyloroplasty as the drainage procedure to accompany vagotomy for the following reasons:

- a. It relieves pylorospasm which is probably a contributing factor in the production or perpetuation of duodenal ulcer.
- b. Pyloroplasty permits direct inspection, confirmation and possible local removal of the scarred ulcer area.
- c. The approach can be used to control an actively bleeding vessel and has been done on three occasions in this series (fig. 1 b).
- d. Pyloroplasty has the advantage of the Billroth I procedure in that the proximity and reflux of the alkaline duodenal content is not disturbed as it is with gastro-enterostomy. Anastomotic ulceration cannot occur.
- e. Pyloroplasty prevents stricturing at the outlet of the stomach as the ulcer heals. It also permits ready emptying of the stomach during the immediate post-operative period when the stomach is temporarily atonic from the recent gastric neurectomy.
- f. Pyloroplasty is much simpler to perform than gastro-enterostomy and is attended by a very low morbidity.
- g. Pyloroplasty does not alter the basic anatomic arrangement of the stomach. This should be of considerable help if at a future date gastric resection should become necessary either for ulcer recurrence or gastric cancer.
- h. Finally, since pyloroplasty alone will cure only 20 per cent of ulcers it is felt that the curative effect of vagotomy would be less obscured than if gastro-enterostomy, which cures 70-80 per cent, was used.

6. Twenty-two patients with proven intractable or complicated duodenal ulcers were treated by means of vagotomy and pyloroplasty.

7. Twenty-one (95.4 per cent) of these twenty-two patients have had excellent results to date. One patient had a short understandable relapse following a two week starvation period during which time he consumed large quantities of coffee and smoked incessantly. Since cor-

rection of this situation he has had no further difficulty and considers himself completely cured.

8. One patient (4.6 per cent) out of the twenty-two is considered as having obtained a poor result, although no anatomical evidence of ulcer or obstruction could be found at re-operation. She was re-operated because of misinterpretation of X-ray findings which were reported as being indicative of deeply penetrating ulcer.

9. The twenty-one satisfied patients have no gastrointestinal symptoms. They have nearly all either gained considerable weight or have maintained their pre-operative weights. None of the patients with pre-operative bleeding has bled since operation. They can eat almost anything they desire. Their bowel habits are more normal and they have taken a new lease on life.

10. There has been no mortality. The average hospital stay was only 6.4 days.

### Conclusions

1. Although this series as yet is too small to permit conclusions to be drawn, the similarity of our results to the results in larger published series of patients who have been treated with vagotomy and a drainage procedure, leads us to believe that vagotomy and pyloroplasty is the treatment of choice for duodenal ulcer.

2. We have obtained 95.4 per cent of excellent results in twenty-two patients with proven duodenal ulcer.

3. It is a safe, simple, satisfactory and physiologic procedure which carries none of the *permanent morbidity* associated with gastric resection.

4. We would like to call attention to the fact that a majority of our cases had more than two vagus trunks. It is failure to find and divide all of the branches that may result in failure to cure the ulcer. Dragstedt infers that 5-10 per cent of operations in inexperienced hands may be incomplete.

5. All patients should be apprized of the fact that cigarettes, coffee and alcohol in excess are apt to be just as harmful post-operatively as they were pre-operatively, because the action of these substances is through direct effect upon the gastric glands and not through the gastric nerves.

6. Post-operative X-ray reports of duodenal deformity following pyloroplasty

should be interpreted in the light of clinical symptoms and not be permitted to stand alone as being evidence of recurrence.

7. Gastric resection, because of the gravity of the procedure, has long been considered a last resort in the management of duodenal ulcer. If vagotomy and pyloroplasty stand the test of time we feel that surgery will be recommended and accepted by the patient sooner, thereby avoiding the risk of many serious complications.

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### DISCUSSION

J. E. Hamilton, M. D., Louisville: I would like to add our experience at Nichols V. A. Hospital to the discussion of this interesting paper especially as our results have been quite similar to those presented by Drs. Dorton and Webb. It is interesting that, although in the early days we were a bit skeptical of the procedure, our residents and staff have of late come to prefer vagotomy to gastric resection in the surgical treatment of duodenal ulcer. This change of view came after two analyses of cases. In the second of these analyses, which appeared in the February 1950 Southern Surgeon, we compared all the vagotomies with all the gastric resections performed for peptic ulcer since the opening of the hospital and felt that there was some superiority of vagotomy over resection. Needless to say the fol-



low-up period has been short and the series small.

So far 60 vagotomies have been done without a death but with a few more complications than noted by the essayists. A number of the cases are too recent for evaluation but I will quote the figures from our recent paper as follows: For vagotomy 76.6% good, 18.6% fair, 4.6% poor or failures. In the smaller series of gastric resections there were 62.5% good results, 33.3% fair and 4.2% failures. Time does not permit description of criteria for "good," "fair" and "failure" but it follows closely those set down by Francis Moore and the Massachusetts General Hospital group.

In view of the more recent tendency, especially in the large clinics and centers, either to discredit or to declare a "moratorium" on vagotomy, we have for some months, and after consultation with Dr. Griswold, been treating every other patient with duodenal ulcer by vagotomy, the alternate patient with subtotal gastric resection.

**Francis Massie, M. D., Lexington:** I would like to ask Dr. Hamilton if he operates regardless of whether they bleed or not, and what type of drainage does he use in vagotomies for obstruction?

**J. E. Hamilton, M. D.:** Regardless of whether they bleed or not or whether they are obstructed or not.

**Francis Massie, M. D.:** What type of drainage are you doing on the vagotomies for obstruction?

**J. E. Hamilton, M. D., Louisville:** That is a good question. We prefer, for many of the same reasons as given by Drs. Dorton and Webb, the simplest type of pyloroplasty namely the Heinicke-Mikulicz. Where it is relatively difficult because of so much scarring and edema in the duodenal region we employ gastro-enterostomy, anterior or posterior, which ever is the easier to do. We are doing them all though the abdomen. We started out performing alternate cases through the thorax but with the abdominal approach you can also explore the local lesion and make pretty sure what you have. I certainly enjoyed the paper just presented.

**R. Arnold Griswold, M. D., Louisville:** My experience with vagotomy goes back about five years, and I would like to make one statement that I think Dr. Hamilton probably forgot to make which he also found in his series. That is that the longer these patients go the better they seem to get. Patients who were in an unsatisfactory or fair class a few years ago have gotten into the satisfactory class. They do seem to get better rather than worse as time goes on. We have had a couple of failures and, of course, you have failures with gastric resection. At the present time we are trying to

differentiate, on a physiological basis, between patients who need gastric resection or vagotomy. This is still experimental.

Originally we did transthoracic vagotomies without a drainage operation. That is where we got into trouble with undesirable side effects. When you do an efficient drainage operation you do not get the undesirable side effects. The combination of vagotomy with a drainage operation gives you less side effects, I feel, than gastric resection and just as good or better a cure rate of the ulcer.

As to the type of drainage operation, I have done gastro-enterostomy in most cases. If you do a gastroenterostomy, it should be done close to the pylorus. We had one case in Dr. Hamilton's series who had a gastroenterostomy and developed gastro-jejunal ulcer. The gastroenterostomy had been done very high on the greater curvature and following vagotomy, he got stasis of the distal part of his stomach. Dr. Hamilton later relieved this with pyloroplasty. My only objection to pyloroplasty in comparison to gastroenterostomy is that in the case in which you need it the worst you may not be able to do it because of scarring, edema, and inability to mobilize the scarred duodenum but, otherwise, I think it is just as good an operation as gastroenterostomy in conjunction with the vagotomy.

I was very much interested in the use of pyloroplasty and vagotomy for active bleeding ulcers. Certainly it would be possible by this means to stop the hemorrhage much earlier in the course of an operation for active bleeding than if one did a gastric resection. Past experience has shown that suture of the bleeding point in a duodenal ulcer was followed by a recurrent hemorrhage within a few weeks. However, the vagotomy done following the pyloroplasty would seem to obviate this difficulty. This suggestion for active bleeding from the pancreaticoduodenal artery is certainly an excellent one.

**Richard G. Jackson, M. D., Danville:** I would like to say that I enjoyed very much the paper on vagotomy and the recent report of results and just mention briefly the experience at the University of Michigan in the series of vagotomies that were done there. This report is not complete in that the study is not complete there. Around a hundred vagus resections were done there and they were discontinued about a year and one-half ago to be studied for a period of time before deciding finally whether vagotomy is a procedure that has lasting merit. However, up to two years ago, sixty-four vagus resections had been done. At first they were all done through the chest and then the operations were done through the abdomen. It was felt that the surgeon could evaluate the situation

better by the abdominal approach in that he could see the stomach and duodenum; complications were fewer, postoperative atelectasis or empyema being less likely, and there was less pain in the wound in the abdominal wall than there often was in the chest wall. Of these sixty-four cases, 64.1 per cent were good, 9 per cent were thought to be poor and the remainder fair. That is, about 90 per cent were good or fair and 9 per cent were poor results. Again, I won't take the time to elaborate on the criteria for the good, fair, and poor results.

I would like to mention one other fact that I think is pertinent. My part of this study was to carry out a series of dissections of fifty cadavers dissecting the vagus nerves from the level of the heart down to their distribution into the stomach. During this study the question arose, "Can the operation be done satisfactorily by denervating only the stomach and preserving the vagus supply to the remainder of the viscera supplied by the vagus?" After a number of dissections had been done, this seemed to be feasible and a method was developed for doing this operation. It would take too long to go into the anatomical basis for the procedure but just to mention it briefly the essential features consisted in dividing the anterior vagus entirely just above or just below the diaphragm taking care to section the hepatic branch of the anterior vagus which goes to the hepatic plexus then gives off the branch to the pyloric region of the stomach. It was thought when Doctor Charles Mayo first did a few vagotomies at the Mayo Clinic back in the 1920's that pylorospasm had something to do with ulcers and Doctor Mayo then divided only this hepatic branch to the pyloric region. This hepatic branch is important since it does supply the pyloric end of the stomach. The anterior vagus is thus divided and tied. The feature of the operation is that in dividing the posterior vagus it is dissected out and the coeliac branch is found and preserved, thus preserving most of the supply to the small intestine and to the large intestine as far as the supply from above goes, that is, the distal transverse colon. This requires a somewhat meticulous dissection, makes the procedure a little more lengthy but seems to be advisable on an anatomic basis in doing the operation as economically as possible by reducing the amount of nerve supply cut. This method was called selective vagus resection. For a year the vagus resections at the University of Michigan were done by this selective method and the two series, that is the total and the selective resections, are now being studied and the final results will be published sometime in the near future. The anatomic basis is important

and I think that I can say briefly that the early results in the two series of operations were about comparable.

**W. L. Estes, Jr., M. D.**, Bethlehem, Pennsylvania: I would just like to say, Dr. Vance, that I appreciate the privilege of being here and have enjoyed these two very interesting and very illuminating papers. I do think one of the most interesting and important points has been brought out by Dr. Griswold, and that is, what are the late results of vagotomy? Certainly the longer these patients are followed apparently their untoward postoperative symptoms seem to improve, but it should be re-emphasized that in the last analysis this operation is going to be evaluated eventually by the final results. We have seen twenty years elapse between one perforation and re-perforation of a duodenal ulcer. Vagotomy for the treatment of peptic ulcer has not been used long enough, therefore, for final evaluation, but I am sure that we all feel it has been a very valuable adjunct to our surgical armamentarium.

**Howard E. Dorton, M. D.**, Lexington (In closing): In treating any disease we should remember that in the first place we should do no harm. We have shown to our own satisfaction that vagotomy and pyloroplasty is a highly satisfactory operation for the complicated duodenal ulcer. We are of the opinion that even if the operation should fail that such a failure would be no more harmful than would failure following medical management. We are satisfied that vagotomy has no harmful effects upon the physiology of the other abdominal viscera, an objection that has been raised by opponents of vagotomy.

On the other hand we are all too well acquainted with the harmful effects of gastric resection. These harmful effects we have named as **permanent morbidity**, whereas the "side-reactions" following vagotomy (which are minimized or eliminated by complementary pyloroplasty) are always transient and never serious when compared with gastrojejunal ulceration, recurrent bleeding, chronic gastritis and so forth which follows in the wake of gastric resection with monotonous regularity.

I would like to emphasize one point that should be carried out following this operation, and that is, that the alterations in the physiology of the stomach following vagotomy should be explained to the patient. This is so that he will not overstretch the temporarily atonic stomach. After each feeding he should recline on the right side in order to allow gravity to empty the paralyzed stomach until intrinsic control returns in from 2 to 3 months.



We are very encouraged to note that our findings coincide with those reported from over the country by other surgeons who are performing vagotomy in combination with a drainage procedure.

**Jack Graham Webb, M. D.,** Lexington (In closing): I am very surprised, and needless to say, pleased that nobody got the axe out in discussing this controversial subject. On the question of pyloroplasty versus gastroenterostomy and the possibility of having cases in which pyloroplasty is impossible because of scarring, we have had a fair number of cases in which there was extensive scarring around the pyloric region and the first part of the duodenum but we have always been able to free up the scar and get an adequate area exposed for this type of pyloroplasty. I presume that we will eventually run across a case in which we can't do it.

In answer to Dr. Massie's question about the indications for vagotomy in bleeding ulcers, we feel that not only cases with history of bleeding but also cases hospitalized for acute severe hemorrhage can be handled by vagot-

omy when coupled with pyloroplasty with direct inspection of the ulcer area, and excision of an anterior ulcer, or suture ligation of the vessel of a posterior ulcer.

Dr. Estes' comment about the fact that the late results will prove the value of the operation is certainly true. That is something that we constantly keep in mind in doing our procedures and that is one reason we feel pyloroplasty the drainage operation of choice because if this operation is going to fail five or ten years from now we want to give the surgeon who is faced with a gastric resection an easier job. We are not certain that it is the answer but we feel very encouraged about the future of the operation. I personally feel about this procedure much as I do concerning the treatment of acute arterial embolism of an extremity. I had rather have a sympathectomy and embolectomy done on me at the time because the leg can always be amputated as a last resort, similarly a stomach can always be resected if the operation of vagus section fails to keep an ulcer healed.

## CENTRAL SEROUS RETINOSIS AND ITS RELATION TO OTHER ACQUIRED IMPAIRMENTS OF CENTRAL VISION

**Arthur H. Keeney, M. D.**

LOUISVILLE

Impairment of central vision, though relatively less incapacitating than loss of peripheral vision, usually is attended with more alarm and anxiety. Lesions affecting central vision with little or no involvement of peripheral fields are quite numerous, and because they differ widely as to therapy and prognosis, a careful differential diagnosis must be made. Some of these processes, such as retrobulbar neuritis, produce no apparent findings in the fundus of the eye; others, such as central serous retinosis, may produce slight macular disturbances which could be overlooked in quick examination with the pocket ophthalmoscope; and still others, such as central exudative choroiditis, produce obvious alterations in the macular area.

### Part I

#### Description of the Entity, Case Report, Therapy

Central serous retinosis is a not too infrequent entity and, in contrast to many

other macular lesions, affords a fairly good prognosis. This is usually a unilateral macular disease, occurring predominantly in males between the age of 30 and 45, and characterized by mild to moderate fogging of central vision. Some patients may notice micropsia, metamorphopsia, and color changes which seem to overcast the vision with a light greyish-yellow or tan hue. The eye is free of usual inflammatory signs and the fundus appearance is one of localized macular edema with slight darkening or greyish tint in the color of the affected area. Using the fine beam of the Friedenwald ophthalmoscope, Walsh and Sloan<sup>1</sup> have shown in several reported cases that the macular changes are associated with clear edema fluid collected between the pigment epithelium and the internal limiting membrane of the retina. Punctate yellowish deposits are often present and may become accentuated as the edema subsides. A relative, central scotoma is usually present. Transient hyperopia is uniformly found and a small amount of plus lens in

Presented at the Monthly Staff Conference, Wills Eye Hospital, Philadelphia, Penn., December 14, 1949.

the refractive correction usually improves visual acuity more than would be expected for the strength of such lens.

The course tends to be one of gradual improvement over several weeks, but is frequently marked by relapses or recurrences. The acquired hyperopia subsides *pari passu* with the macular edema.

The pathogenesis of central serous retinosis is uncertain but seem without relation to infections or to the systemic blood pressure. Several investigators have considered it due to angiospasm of the smaller arterioles<sup>2,3</sup> or to "capillarosis"<sup>4</sup> about the vulnerable macular area. Some tenuous evidence has been adduced from the study of skin capillary mechanisms<sup>5</sup> in which an increased amount of spasm has been demonstrated. Botham<sup>6</sup> and Bettman<sup>7</sup> would place the primary disorder on an allergic basis compatible with such circulatory disturbances but they have not produced conclusive evidence.

### Clinical Entity

This clinical entity has been described by many names but the designation central retinosis seems to describe the process most accurately in so far as it is currently understood. The following synonyms appear in the literature:

1. Retinitis centralis (Asayma 1898).
2. Central serous retinitis (Matsuda 1920; Contardo 1946; Stenstrom 1943).
3. Chorioretinitis centralis serosa (Kitahara 1936; Brucker 1945; Kurz 1947).
4. Retinitis centralis angiospastica and Retinitis centralis capillarospastica (Horniker, 1929).
5. Retinitis centralis annularis (Krupa, 1923).
6. Preretinal edema (Guist, 1925).
7. Central serous choroiditis (Riehm 1938; Duggan 1942; Bonnet 1946).
8. Central angiospastic retinopathy (Gifford & Marquardt 1939).
9. Idiopathic flat detachment of the macula (Walsh & Sloan 1936).
10. Central serous retinopathy (Philips 1946).

### Case Report

A forty year old Philippine male was admitted to the Wills Eye Hospital on the service of Dr. Wilfred Fry, November 5, 1949 complaining of diminished central vision in the right eye without pain, injury or other apparent cause. He states

that his sight has always been good and essentially the same in both eyes until three days prior to admission when he noted blurring and fogging of vision in the right eye. There was no micropsia, metamorphopsia or color disturbance. He had obtained a non-cycloplegic refraction two weeks prior because of mild difficulty with near vision in dim light during the past year. A pair of glasses O. D. + 0.87, O. S. + 0.75 had been dispensed "for reading only."

The patient is a well developed and nourished laborer, 64¾ inches tall and weighing 142 pounds. For ten years he has worked in the manufacturing division of a large storage battery company where apparently adequate protection is afforded against industrial toxins. His previous history is negative except for mild hay fever marked by moderate sneezing and lacrimation each October. A brother with whom the patient lived died of TB in 1932. The family history is entirely negative according to the patient.

On admission the uncorrected vision was O. D. 20/100, O. S. 20/40. With his mild plus correction this improved to O. D. 20/40 — and O. S. 20/20. No further improvement could be obtained with a pinhole. Routine external, slit lamp, and ophthalmoscopic examinations were negative except for the right macula. This area appeared hazy, was slightly elevated, and had no foveal reflex. The color was darker red than that of the surrounding retina or opposite macula, and was studied with one small, irregular area of yellowish hue above and temporal to the site of the fovea. No central scotoma could be elicited with a 1 mm. white test object on the Lloyd stereo-campimeter. General physical examination was negative.

### Hospitalization Studies

Blood Kahn and Wasserman tests were negative. No agglutination of the patient's serum in dilutions of 1:10 through 1:320 with the antigen of *Brucella abortus*. Blood cholesterol 218 and sugar 87 mgm. per 100 cc., the routine urinalysis normal. Normal blood count except for 10% eosinophiles. No organisms or pus cells in the prostatic secretions, the basal metabolic rate was 3%. Oral hygiene fair except for several caries; dental X-rays were negative. Three plus local reaction to 0.002 mgm. PPD intradermally. Normal capillary function studies in the skin of upper extremities were:

- a. Gothlin index of capillary fragility:



zero (normal is 0.1, or 2).

- b. Cutaneous lymph flow with patent blue dye as index of capillary filtration: one-half inch in 15 min. (normal: less than three-fourths inches).
- c. Normal mobilization response of capillary loops after intradermal histamine.

Scratch tests for common allergenic inhalants were negative. Normal cutaneous reaction to intradermal test for histamine sensitivity (0.05 mgm).

### Therapy

The course of this patient under treatment has been one of gradual improvement. On admission he was given a mild Magnesium Sulfate catharsis and placed on restricted fluids. Treatment with adrenalin in oil by IM injection three times a day for three days, combined with thyroid extract gr. 1 daily did not produce appreciable improvement. On the 8th day (Nov. 10) he was started on a course of five intravenous injections of typhoid vaccine given q.o.d. The initial dose was 15 million killed organisms and this was increased by 10 million at each subsequent injection. Good febrile responses were obtained and the edema and discoloration of the macula cleared somewhat but his vision did not improve. A trial of sodium nitrite one grain I. V. t.i.d. on November 11 was without immediate effect. On the 13th day (Nov. 15th) nicotinic acid was added to his regime in doses large enough to produce flushing of the skin, about 100 mgm. t.i.d. by mouth. The elevation of the macula continued to subside. At the time of discharge, November 19, his vision was O. D. 20/40+ (with pin-hole) and a circumscribed area of slightly darker color could still be seen in the macula with the aid of red free light.

Twenty-four days after onset of symptoms the vision had returned to 20/30 (pin-hole) and at one month (Dec. 2) his correction under homatropine was O. D. + 1.75 + .50 x 120=20/30+2, O. S. + 1.50 +.25 x 90= 20/20. There was no change on re-examination a week later.

This patient, like others reported in the literature, has followed a favorable course under treatment with vasodilators. Therapeutic measures of various investigators can be broken down into three groups based on variations in the concept of pathogenesis. These are: (a) measures aimed at vasodilation, (b) anti-allergic management, and (c) general measures.

The combination of these approaches seems to reduce the severity of attacks, shorten the period of illness, and make for less frequent recurrences.

Specific measures which are sound and have been found useful by various investigators are:

(A) For vasodilation:

1. Papaverine: up to 120 mg. by mouth or intra-venous, two or three times a day.
2. Nicotinic acid: "flush doses" of 50 to 150 mgm. by mouth four times a day.
3. Depropanex (insulin free pancreatic extract): 3 to 4 cc. intra-muscular daily in acute stages; 1 cc. intra-muscular every other day for two weeks.
4. Erythrol tetranitrate (undiluted): 15 to 30 mgm. three times a day by mouth.
5. Priscol (benzyl-imidazoline) 25 to 50 mgm. by mouth every other day or 10 mgm. by retrobulbar injection every other day.

6. Na nitrite: up to 100 mgm. intra-venous or by mouth, three times a day.

7. Killed typhoid organisms: lower doses of 5 to 10 million organisms, intra-venous.

8. Barbiturates as indicated for hyper-tonicity and restlessness.

(B) Anti-allergic therapy:

1. Skin tests with various allergens and hypsensitization courses as indicated.

2. Anti-histaminics.

3. Epinephrine in oil 1:1000: 1 cc. intra-muscular four times a day for several days in hyperacute allergic states with associated central serous retinosis.

(C) General measures:

1. Eliminate focal infections and toxic factors.

2. Correction of any metabolic disturbances with particular attention to low and sub-clinical degrees of hypothyroidism.

3. Rest and relief from tension and anxiety<sup>8</sup>.

4. Indicated treatment for any existing peripheral vascular or capillary faults.

5. Avoid vasospastic agents such as cold and tobacco.

### Part II

#### Relationship to Other Acquired Impairments of Central Vision

Clinical differential diagnosis in a given case usually revolves about no more than four or five entities but all of the following disorders of central vision have fea-

tures which may be confused with central serous retinosis and, at times, require differentiation. These are all painless conditions, without external eye manifestations, and are brought to the patient's attention by impairment of central vision.

### **Central Choroiditis**

Early Central Choroiditis of the common, circumscribed type produces pigment disturbances in the macula and mild inflammatory signs in the vitreous and anterior chamber which are not present in central serous retinosis. Visual loss is usually greater, has a more rapidly unfavorable course, and is without hope of improvement.

### **Acute Axial Retrobulbar Neuritis**

The initial episode of this unfortunately common disturbance usually occurs before the age of 40 and is unilateral. Visual loss is without micropsia or metamorphopsia and a careful examination of the macula shows no abnormalities. The cause is usually multiple sclerosis but subsequent episodes or other manifestations of the disease may not appear for months or years. The optic nerve head is of normal appearance unless a neural plaque happens to be very close to the globe, in which case swelling of the nerve head and associated enlargement of the blind spot will be seen.

### **Senile Degeneration of the Macula**

According to Haab this is due to sclerosis and obliteration of the choriocapillaris in the macular area and is a common cause of central visual loss in older people. Early findings are punctate stippling and pigment disturbances in the macula. These are more easily seen with the ophthalmoscope when red free light is used. Involvement is usually bilateral though one eye is commonly more affected than the other. Temporary help can be offered to these patients with stronger lenses, telescopic spectacles, and other optical aids, but the degeneration progresses slowly and relentlessly.

### **Juvenile Disciform Degeneration of the Macula**

Juvenile exudative macular choroiditis is usually unilateral but develops more slowly and appears in the 2nd or 3rd decades of life. There are no inflammatory signs but retinal hemorrhages are commonly present about the involved area and pigmentary disturbances are marked.

The subretinal exudate tends to resolve in 2 to 6 months and the prognosis for vision is fairly good.

### **Idiopathic Juvenile Degeneration of the Macula**

These lesions are generally bilateral and begin in the 2nd or 3rd decade of life. The macula may be flat or unusually concave and shows fine punctate disturbances in its coloration. The loss of central vision is steadily progressive but the patient can be reassured that peripheral vision will not be involved.

### **Berlin's Edema**

Berlin's Edema (Commotio retinae): This type of visual disturbance is caused by contusion or other physical trauma to or near the eye. There is characteristic a diffuse pale edema of the macular area which produces a relative central scotoma for blue with well preserved perception of red. A central scotoma for white occurs with more serious commotio and indicates an unfavorable prognosis for central vision.

### **Cystic Degeneration of the Macula**

Careful ophthalmoscopic examination, particularly with red free light, reveals multiple small clear cysts in the macula. Traumatic cases usually follow contusion. Non-traumatic cases are more common in older individuals and in cardiovascular patients. The course is progressive and often leads to a "hole" in the macula with irreparable loss of central vision.

### **Leber's Disease**

Leber's Disease (Hereditary optic atrophy) has a rapid onset and predilection for males, as does central serous retinosis. It is practically always bilateral and commonly develops between the age of puberty and early adulthood. Rarely the onset is delayed until the age of 40 or 50. The central scotoma is usually dense and peripheral field defects may also be present. Though there are no local disturbances in the maculas, some pallor and atrophic changes can usually be seen in the temporal portions of the optic nerve heads. Prognosis for central vision is poor.

### **Actinitic Retinitis**

In Actinitic Retinitis (Eclipse blindness) the visual symptoms and early macular edema may resemble central serous retinosis, but the cause is usually revealed by a history of solar or thermal exposure. Prognosis depends on the duration and



intensity of phototrauma but should be guarded in all cases.

### Toxic Amblyopias Producing Central Visual Defects

These are practically always bilateral and the history contributes to the diagnosis. Iodine, inorganic arsenic, tobacco and lead are more common offenders. Lead could be considered in the case reported here because the patient is a battery maker; however, no other symptoms of lead poisoning (such as headache, colic, or wrist drop) were present and both lead amaurosis and lead retinitis occur only in the late stages of intoxication.

In tobacco amblyopia, patients often complain of vague central visual disturbances of many weeks duration. Ophthalmoscopic examination reveals no pathology in the macula, and slight color disturbances may or may not be present in the nerve head. Central field examination shows a characteristic centrocecal scotoma for red and usually a smaller scotoma for white. Spontaneous improvement in all but the most neglected macula cases, can be expected in one to three months after discontinuing tobacco.

### Circumscribed Detachment of the Macula of Neoplastic Origin

Minimal findings of edema and discoloration are noted at first but usually the lesion will be seen to progress and expand within the period of a few weeks. Enucleation of the eye is indicated as soon as the diagnosis is assured.

### Posterior Detachment of the Vitreous

Usually a pre-existing focus of chorio-retinitis will be seen, and dehiscences or "hyaloid holes" may be found in the surface condensation of the vitreous. A distorting shadow may be cast over the macula. Photopsiae or flashes of light similar to those caused by retinal separation may be reported initially. The importance of this lesion lies in the frequency with which retinal separation may follow.

### Central Relapsing Retinitis

Central Relapsing Retinitis (Von Graefe, 1866) is a rare manifestation of late syphilis and produces a large yellowish patch in the macula followed by atrophic changes.

### Heredo-Familial Degeneration of the Macula

These are typically bilateral lesions and several members of an affected family will show lesions which are generally

identical in morphology, age of onset, and course. The absence of central nervous system changes differentiates this group from the Batten-Mayou type. Ophthalmoscopic appearance of the lesion may vary somewhat but pigment alterations and greyish-white colloid-like bodies are generally present in the retina and confined to the central area. The course is progressive and ultimately results in absolute central scotomas.

### Occlusion of Cilio-Retinal Artery

This manifestly depends upon the presence of such a vessel. Careful inspection with the ophthalmoscope will reveal diagnostic pallor and edema along the course of the artery between the nerve head and the macula. With the aid of vasodilators, a good prognosis can be made.

### Summary

Central serous retinosis has been described as an acute macular lesion, usually unilateral, characterized by moderate impairment of central vision and transient hyperopia. The only findings in examination of the eye are confined to the macular area and consist of edema, slight discoloration and some yellowish stippling. Although relapses may occur, the prognosis for the episode is good. Treatment with vasodilators and antiallergic management as indicated probably reduce the severity and duration of the illness. An illustrative case is reported and the relationship to others acquired, painless disturbances of central vision is discussed.

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**Tuberculosis in industry can be controlled as an integral part of a general health program, although constant vigilance is indicated.** Fred B. Wishard, M. D., *Am. Rev. Tuberc.*

## CHRONIC AMEBIASIS; DIAGNOSIS AND TREATMENT

Colonel Ryle A. Radke, M. C., U. S. Army

FORT KNOX

The data upon which the conclusions drawn in this paper are predicated have been gathered at Fort Knox Station Hospital from the study of 109 cases of chronic amebiasis seen there on the Medical Service during the past twenty-four (24) months, all of whom were examined and treated by me. It is not my intention to review the literature of amebiasis. Those of you who are interested or stimulated by my remarks this afternoon might well consult Craig's<sup>1</sup> monograph on the subject of amebiasis.

### Incidence

The incidence of amebiasis is variously estimated as being between 10 and 15% of the population of our country. Faust<sup>2</sup> has shown that the incidence increases as the tropics are approached. I would caution you against accepting the thought that amebiasis is a tropical disease. It is far from that. The first described case by Losch<sup>3</sup> was in a resident of St. Petersburg, Russia, which as you know is nearly at the Arctic Circle. Amebiasis has repeatedly been described in every climate and some of the cases we are concerned with this afternoon are indigenous to Kentucky.

### Method of Transmission

The disease is transmitted by the ingestion of cysts, thus the epidemiology of the disease is that of any disease of filth, namely, infected water and food. In three recorded epidemics which were studied carefully, there was a cross-connection between the sewer and water supply systems<sup>4,5,6</sup>. There appears to be little doubt that water is a potent source of infection with the *Endamoeba histolytica*. Food infected either by use of infected feces for fertilizer or through infected food handlers is a potent source of sporadic cases. One group of eight cases in this study, apparently, resulted from eating raw oysters in a foreign country. One family group of three appears to have been infected by the husband who likes to cook and make tossed salads.

The data we have gathered appear to point directly to a previously little stress-

ed facet of this condition, namely, that successful treatment in this disease necessitates a survey of the family and other intimate contacts, just as is being widely practiced in the management of tuberculosis. After this fact became apparent to us we made it a practice to survey the family whenever possible. As a result we have found the disease in forty-five (45) cases which were members of seventeen (17) families, ranging from 2 to 5 members. An example of this fact is a man whom we diagnosed and treated and found negative as far as the 9th post-treatment month, only to find him infected again on the 12th monthly examination. We believe that rather than this being a relapse, the reappearance of the amebae was adequately explained as a reinfection when we found he was being served by an infected cook, namely, his wife. It is important for us to investigate the background and family of the cases of amebiasis which we see. Thus, one family group of three in the present study was, undoubtedly, infected from a contaminated well. I would like to present for your consideration the futility of treating one member of this family or not investigating the water supply. The patient would be a treatment failure, no matter what drug was employed.

### Symptomatology

A discussion of the symptomatology of a disease ought logically to concern itself with the patient's presenting complaints. I will endeavor to assess this aspect of the question from the data gathered from our group of patients. Apparent at once was the fact that only 16 of these 109 patients with chronic amebiasis presented themselves with the complaint of bloody diarrhea. The common presenting complaints were fatigability, irritability, joint aches and pains, allergic skin manifestations, fever, pain in the right upper quadrant, migraine, scrotal pain, pain in the right breast, pain in leg, and pruritus ani. Certainly nothing is specific in the presenting complaint of these patients. On the other hand, it very soon became apparent that there must be a common denominator somewhere in the syndrome because people with amebiasis would say to their



friends who had been overseas with them, "Your symptoms are similar to mine and probably you have amebiasis also."

### Typical Onset

We are confident that we have unearthed the common denominator. The typical onset occurs with an explosive attack of diarrhea, often bloody, which is treated and responds somewhat to sulfadiazine and/or penicillin. This is followed by intermittent lower abdominal cramping, intermittent diarrhea again, not infrequently bloody, and by a symptom which we have called "precipitate stool" which is really fecal urgency: a sensation of extremely urgent call to stool out of a clear sky as opposed to the normal where urgency does not supervene until a number of lesser calls have been had and disregarded. A precipitate stool is apt to be termed diarrhea by some patients, but is really a soft stool. Frequently, such a stool is followed by several days of so-called constipation. However, if the history of precipitate stool is carefully taken one is often able to elicit the story that clearly recognizable food particles of the last meal taken 2 to 3 hours previously were seen in the precipitate stool. Thus, the constipation is more the result of the bowel being cleared from stomach to rectum by the urgency of the precipitate stool. Another commonly encountered symptom is that of flatulence or bloating. Ladies wearing tight girdles complained of this. An interesting by-product of our preoccupation with families has been the recognition of amebiasis in 10 youngsters, aged 12 years and younger. In these we have been able amply to confirm the point which was made by Marks<sup>7</sup>, Loeber and D'Antoni<sup>8</sup>, namely, that amebiasis in the young is apt to be interpreted by the parents and the doctor as a manifestation of behaviour problem. Without exception, the mothers of this group of patients testified that their little one had become most difficult to manage, and had, in addition, had nausea, vomiting, vague gastro-intestinal pains and precipitate stools.

### Diagnosis

Diagnosis of amebiasis can only be made by recovery of the organism from the stool of the patient or in specimens secured through the sigmoidoscope. The recognition of this organism is difficult and probably is best accomplished by means of direct smear technic, on a warm specimen examined at once with micro-

scope with a warm stage. If cysts alone are seen these are best stained by the iodine technic of D'Antoni. My conviction is that the best specimens for examination are those obtained through the sigmoidoscope and, also, that they should be examined right in the room where the specimen is obtained. There are two reasons for my belief in the superiority of specimens obtained through the sigmoidoscope; first, that when lesions are seen in the rectosigmoidal area, one is not content with a single negative examination; secondly, even though lesions are not seen the mucus from the fecal stream is often blood-tinged, and it is in this type of specimen that your technician has the best hunting. In my experience recto-sigmoidal lesions from which amebae have been pipetted have been present in 89% of the 109 cases. My percentage is somewhat at variance with that reported by Craig<sup>1b</sup>. However, I believe that a careful search for the lesions, particularly on the proximal surface of the valves of Houston, and in the lower sigmoid colon with particular thought to the smallness of the lesions will reward others to the same degree. It is noteworthy that my percentage is completely in accord with that recorded by Manson-Bahr<sup>9</sup> and Hinman and Kampmeir<sup>10</sup>. Clark<sup>11</sup> reported from Panama that 74% of amebiasis cases autopsied had lesions involving the recto-sigmoidal area among other portions of the bowel. This is clearly more nearly in accord with my data than it is with the data which recto-sigmoidal lesions are said to occur in less than 50% of cases.

### Diagnostic Approach

I would suggest that a diagnostic approach to a patient suspected of amebiasis be as follows: 1. Examination of a fresh warm stool. The importance of the immediate examination of the specimen cannot be overstressed. In addition, some technic of maintaining a warm stage must be practiced. If the search for trophozoites is unsuccessful this specimen should be further examined by the zinc sulphate flotation technic for cysts, which if found must be stained for identification. 2. Examination of three stools following a saline purge, after discarding the first. 3. If unsuccessful in steps 1 and 2 then sigmoidoscopic examination 10 days following the purge with employment of the immediate examination of aspirated specimens from visible lesions or, if there are none then of mucus pipetted from the

fecal stream. We have found examination of aspirated material to be most discouraging within the first 10 days after a saline purge or barium given for X-ray examination or bismuth given for control of diarrhea. Apparently the excretion of organisms is inhibited by the action of these materials. In several of the cases under consideration in the present paper the diagnosis was not established until 4 or more smears from each of 3 or more examinations with the sigmoidoscope were made. In fact in three of the cases presently under discussion, the diagnosis was established by culture performed for us by Dr. James Shaffer of the University of Louisville School of Medicine, no ameba or cysts having been found in repeated smear examinations. Hence, if all the steps listed above are negative and the history is still suggestive, I would repeat step 3 at ten day intervals. A further practical point which we have found important should be stressed here, namely, that inexperienced technicians frequently differentiate *E. nana* from *E. histolytica* solely on the basis of the small size of the *Endolimax nana*. This results in missed cases of amebiasis because there is a race of small *E. histolytica*, which is every bit as small as the *E. nana*. I have made it a rule to sigmoidoscope all patients in whose stool we find *E. nana*, and a surprising number of them are found to harbor both the small race of *E. histolytica* and the *E. nana* organisms.

An additional diagnostic point should be made, which is that all cases of hepatomegaly not otherwise readily explainable should be assessed diagnostically for amebiasis. Five of the 109 cases presently under scrutiny were sigmoidoscoped primarily because of hepatomegaly discovered at routine physical examination. There were 25 cases in the 109 with large tender livers. These usually had some slight aberration of their liver function tests as well as the hepatomegaly. A typical liver profile of this group would show an icterus index of 12, Bromsulfalein retention of 5% or 10% at 45 minutes with 2 mgm per kilo dosage, cephalin flocculation test either normal or 3 plus at 48 hours, strictly speaking this represents hepatitis without jaundice. From a historical point of view these 25 cases of amebiasis with hepatomegaly all presented a story of right upper quadrant distress not infrequently combined with exacerbation of the distress on movement or jarring. Most of them also remarked

that alcohol disagreed with them. In some of them the distress was apparently exacerbated by intake of food, particularly fatty ones, in equally as many this was not the case. The radiation of this distress was frequently to the back and in one case to the right breast.

### Treatment

Treatment of amebiasis became possible on a specific basis with the introduction of emetine as a result of the work of Vedder<sup>12</sup> and of Rogers<sup>13</sup> in 1912. However, it very quickly became apparent to thoughtful observers that emetine was a dangerous drug resulting in peripheral neuritis, myocardial damage, and extremely painful local reactions at the site of injection in a fairly large percentage of the patients treated. In addition, it was quickly apparent that the drug was not successful in eradicating the infection from the bowel, in an appreciable number of patients. In the continuing search for more suitable therapeutic agents, arsenic compounds were found useful, as well as iodine compounds, and the British profession has found emetine by mouth as Emetine, Bismuth, Iodide to be valuable. The least toxic of the arsenic compound presently available is carbarsone. The most useful of the iodine compounds in our hands has been diodoquin, in dose of 0.63 gm thrice daily for 20 days.

### Use of Atabrine

As a result of a case treated at Letterman General Hospital in 1946, I became interested in the employment of atabrine in therapy of this condition. In a study conducted at Fort Knox, I found that atabrine was apparently amebicidal in vitro and in vivo, this work is being published<sup>14</sup>. As a result of my experience with atabrine, I became convinced that it would not in all instances eliminate the cysts of *E. histolytica*, consequently, I have combined it with carbarsone in every case except where idiosyncrasy to carbarsone existed. My reason for employment of carbarsone was that it appeared to be most effective in eliminating the cysts in our in vitro studies. I have employed a dose of 0.1 gram of atabrine four times daily for 15 days and, concurrently, 0.25 grams of carbarsone thrice daily in the male and twice daily in the female patient for ten days, proportionately smaller doses were employed in the children. Sixty-nine cases of the group of 109 were treated



with atabrine-carbarsone combination and have been followed at least three months. The relapse rate has been 12%. Complications to therapy, have been few. All patients given doses of atabrine of this magnitude become stained yellow. This promptly disappears after the drug is discontinued. One case developed what appeared to be toxic delirium while on atabrine and carbarsone. This disappeared promptly when medication was discontinued. Three cases developed skin rash while on carbarsone therapy. In one case this appeared to be exfoliative dermatitis, the other two were finely granular erythematous lesions resembling an allergic reaction, all disappeared promptly upon discontinuance of the carbarsone and in two instances upon therapy with BAL. All three cases were subsequently treated with atabrine-diodoquin combination with no recurrence of the skin difficulty. Fifty per cent of the atabrine carbarsone treated cases were treated on an outpatient status. Before therapy with carbarsone is started, it is my custom to get a white blood count and differential blood count and urine analysis to make certain that no aberration exists and, also, to have the data available in the event complications to the arsenic are suspected.

#### Use of Chloroquine

As a result of Conan's<sup>15</sup> published report of the efficacy of chloroquine in treatment of amebiasis, particularly of the liver, thirty-eight (38) of the present group of patients were treated with a combination of 0.25 gms of chloroquine four times daily for 15 days and 0.25 grams carbarsone thrice daily for male and twice daily for female patients for ten day. Every patient that we treated with the above dosage of chloroquine developed nausea and eye symptoms which were described as consisting of difficulty in focusing and in distinguishing near from distant objects. In two cases not included in the thirty-eight (38) mentioned above, therapy with chloroquine was discontinued because of the severity of these symptoms. Results of this treatment briefly are that 78% either did not respond to the initial therapy or relapsed within 90 days. In thirteen (13) cases of thirty-six (36) treated with chloroquine-carbarsone in which rectal lesions were visible by sigmoidoscopic examination, the lesions did not heal. As a result of the data presented above we have reached the conclusion that atabrine combined with carbarsone

is the treatment of choice in amebiasis irrespective of the presence of hepatic involvement.

#### Penicillin-Sulfadiazine Therapy

As pointed out by Hargreaves<sup>16</sup> there is a large factor of bacterial invasion of the tissues surrounding the amebic lesions which plays an important role in symptomatology and in response to specific therapy. In five acute bloody dysentery cases, of the group presently under discussion, penicillin in doses of 50,000 units every three hours and sulfadiazine in doses of 0.1 gm per kilogram of body weight were employed therapeutically prior to the start of the antiamebic therapy. In each instance the symptomatic relief was dramatic, however, the ulcerations did not heal in spite of the fact that the surrounding areola of redness disappeared and the cellular content of the aspirated material changed dramatically, no longer containing macrophages and polymorphonuclear leucocytes. Also, in each instance the symptoms recurred promptly upon discontinuance of the penicillin-sulfadiazine therapy. In my opinion the control of secondary infection is an important factor in management of this disease and as Hargreaves has shown should be included in the management of severe and relapsing cases. In the present group of 109 cases this was included in the management of the five cases mentioned above only because it was my desire not to becloud the issue of the effectiveness of atabrine-carbarsone and chloroquine-carbarsone by the employment of adjuvant therapy.

#### Aureomycin Therapy

A similar effect can be obtained with aureomycin with considerably less difficulty. McVay, Laird and Sprunt<sup>17</sup> have shown that aureomycin has a useful effect in the management of amebiasis. The dosage they are employing is 0.5 grams four times daily for 7 days, and they have reported that a number of their cases are cured. They stress the fact that they are not certain whether the effect of the drug is on the ameba or secondarily, through its effect upon the bacterial content of bowel. We have employed aureomycin in 250 mgm dosage twice daily for five days on three cases not included in the 109 mentioned above with dramatic relief of their symptomatology within the first 2 days of employment of the drug and in two instances with improvements

in the appearance of the visible recto-sigmoidal lesions. Each of these three cases were free of ameba for a period of 21 days following this therapy, but in each instance the lesions got worse and the *E. histolytica* were recovered from the stool without difficulty after three weeks had elapsed. The analogy between this small group and the small group treated with penicillin-sulfadiazine seems clear. Hence, I believe that management of difficult relapsing cases with the addition of aureomycin in doses of 250 mgm twice daily for five days to the atabrine-carbarsone dosages mentioned above is indicated. If aureomycin is not available for treatment of such a case then the employment of penicillin-sulfadiazine concurrently with the atabrine-carbarsone is indicated. We have employed aureomycin 250 mgm twice daily for five days combined with atabrine-carbarsone in a group of cases which had relapsed following other types of therapy. In each instance the symptoms cleared within a much shorter time than when atabrine-carbarsone was employed alone. This group has not yet been followed sufficiently long to assess the effect of the addition of aureomycin on the long range treatment success. Used in such small doses aureomycin does not usually cause nausea, vomiting and diarrhea, although 10% of this group of 25 cases vomited on the fourth or fifth day of the employment of such doses given concurrently with 0.1 gram of atabrine four times daily. It is fair to state that in some individuals vomiting occurs with atabrine alone in the above doses.

One of the 109 cases was seriously ill with liver abscess and pleuro-pulmonary involvement. He made a complete recovery treated with atabrine, aureomycin and carbarsone. This has been reported in detail and will be published in the medical Literature.

The cases with hepatomegaly without exception had regression of their livers to normal size whether treated with chloroquine or atabrine. Two of the 109 cases were pregnant females and were treated with chloroquine-carbarsone without incident except that vomiting was severe in each case and in one was thought perhaps to be due to carbarsone so diodoquine was substituted. Each was a choroquine treatment failure and was subsequently treated with atabrine without incident, except that the lady previ-

ously thought to be vomiting due to carbarsone developed an allergic skin rash the second day of her combined atabrine-carbarsone therapy which cleared promptly when the carbarsone was discontinued.

### Other Phenomenon

A further phenomenon concerned with chronic amebiasis needs mention at this time, and that is the curious fact that frequently patients with this disease have recurrences of their symptoms after therapy even though careful examination does not reveal evidence of relapse. My opinion regarding this is that these represent recrudescences of symptoms due to a conditioned reflex mechanism, for certainly a disease which has been present for a period of months must have had symptoms of bowel distress due to the disease happening concurrently with other extraneous stimuli which stimuli subsequently may be capable of initiating the chain of unpleasant sensations regardless of the fact that the ulcers originally responsible for the symptoms are now healed. Each of these cases demands a most careful evaluation to make certain that the disease itself has not recurred, because amebiasis is a most difficult disease to eradicate. I believe that each treated case should be carefully evaluated upon completion of therapy and again in 3 months before the patient is discharged from observation. Our recheck examination is done by means of four wet smears and one culture, all obtained by means of the sigmoidoscope.

### Summary

Amebiasis is a very common disorder. It is possible to suspect its presence from history of acute diarrhea, frequently bloody, followed by chronic occurrence of precipitate stools, lower abdominal cramping, flatulence, fatigability, irritability, and mild joint aches and pains with lower abdominal pain and cramping and in 25% of cases, right upper quadrant distress made worse by movement, jarring or intake of alcohol. Physical examination reveals tenderness of right or left lower quadrant or both and in 25% large tender liver. The diagnosis rests upon the demonstration of *E. histolytica*, trophozoites or cysts in smears of bowel contents obtained by freshly passed specimens or in specimens obtained after saline purge or in aspirated material obtained during sigmoidoscopic examination. Not infre-



quently, repeated examinations are necessary to demonstrate the organism and in 3 of the 109 cases discussed, the organism was demonstrated by cultural technic only<sup>18</sup>.

When the presence of amebiasis is proven it is important to examine the remainder of the family and the water supply of rural patients. In our experience the best therapeutic regime is the combination of atabrine in dosage of 0.1 grams four times daily and carbarsone 0.25 grams thrice daily in male adult and proportionately less in female and small persons. We have had a failure rate of 12% with this regime. Chloroquine in dosage of 0.25 grams four times daily combined with carbarsone 0.25 grams thrice daily resulted in a failure rate of 78% and thus is not recommended.

In severe cases and in those that have relapsed following therapy, the addition of drugs designed to control the bacterial infection is important. Our data suggests that aureomycin 250 mgm twice daily for five days is a useful addition to atabrine and carbarsone in the recommended doses.

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## HEMANGIOMA OF THE ILEUM WITH INTUSSUSCEPTION

Richard H. Weddle, M. D.

SOMERSET

The discussion of benign tumors of the small intestine has been frequently reported throughout the literature and the occurrence of such tumors are known for their rarity. In 11,500 autopsy specimens and 45,000 surgical specimens Dr. T. S. Raiford (1) reported a total of 88 tumors of the small intestine of which 50 of these were benign. In reporting 41 cases of benign tumor of the small bowel at the Mayo Clinic, between the years 1907 and 1939, Weber and Kirklin (2) listed the tumors in order of frequency as myoma, adenoma, lipoma, fibroma, hemangioma and osteochondroma. These tumors are found most commonly in the duodenum, secondly in the jejunum with the ileum

occupying third place. In a collective review of 38 intestinal tumors of vascular origin Lazarus and Marks (3) found most of these tumors to occur solely in the small intestine; only 8 being found in the colon alone. Of these reported 38 intestinal tumors of vascular origin the lesions were designated as nevi 6, angioma 11, cavernous hemangioma 11, capillary hemangioma 5, varicosities 2, cavernous phlebectasis 1, and two tumors were not designated. In reviewing the literature relative to intussusception there is no apparent causative factor found in the vast majority of cases. Oberhelman and Condon (4) presented a study of 95 infants and children admitted to the Cook County Hospital between 1925 and 1945 with a diagnosis of acute intussusception. In

this series, they were unable to find an initiating factor in 85 per cent. Of those patients, 68% were under 1 year of age and the most frequent findings in their series were listed as vomiting, followed in order by pain, and bloody stools. There are the less frequent findings of a palpable mass and signs of intestinal obstruction. These two reporters considered the disease to be primarily a surgical emergency and in those requiring resection, there was a mortality rate of 42.8 per cent. There were five cases of ileo-ileal intussusception requiring resection, and the mortality rate for these was 60%. It is with these few figures relative to the occurrence of small bowel tumors and particularly the angiomatous tumors of the small bowel and these few factors concerned with intussusception that I wish to present to you an interesting case of ileo-ileal intussusception with a cavernous hemangioma located at the fulcrum of the intussusceptive portion of the ileum. This case approaches three such cases reported by Dr. P. S. Hansen (5).

### Case Report

E. B., a white male, aged 7 years, was admitted to the hospital April 30, 1948, complaining of pain in the right lower quadrant which had been present for two days. There was occasional transient pain in the epigastrium, but none associated with the periumbilical region; none in the costovertebral angles. Vomiting occurred the evening before admission to the hospital, and also on the morning of admission. The vomited material was said to have the appearance of bile and mucus. The child had had three bowel movements after the onset of pain, with no abnormalities noted in the stool. Prior to the onset of pain, he had been active, but shortly after became somewhat lethargic, with no inclination to eat, and remained quiet in bed until his hospital entrance.

### Past History

The child had always been rather pale, although quite active. At the age of 1 year, he had been seen in one of the university hospitals with a small mass in the region of the left axilla. This was said to have been a hemangioma. The treatment consisted of radiation to the mass, with multiple blood transfusions. He did very well following this, until the age of 6 years, when a mass re-appeared in this

same area extending over the anterior portion of the upper left chest. He was re-admitted to the same hospital, and was found to be markedly anemic. He was given multiple blood transfusions, and the mass was resected, the pathologic diagnosis being hemangioma. The operative note stated that the tumor mass had apparently involved the intercostal spaces from the first to the third ribs. Other past history was not contributory, except that it was ascertained that the child had always had a poor appetite, particularly from the standpoint of protein intake.

### Physical Examination

The patient appeared extremely pale, lethargic, and undernourished. He was lying quietly in bed with the thighs flexed on the abdomen. Temperature 100° F., pulse 130, respiration 20, blood pressure 100/54. There was marked circumoral and periorbital pallor, and the nail beds appeared somewhat cyanotic. The buccal and pharyngeal mucous membranes were very pale. The posterior cervical lymph nodes were palpable. One small lymph node was palpable in the right axilla. A surgical scar, two inches in length, was present along the left lateral pectoral border. The thorax showed equal expansion, with vesicular breath sounds and a resonant percussion note throughout. The heart was minimally enlarged, extending midway between the nipple line and the anterior axillary line in the sixth left interspace. The point of maximum impulse was diffuse, heaving, and rapid. A slight systolic murmur heard both at the apex and at the base of the heart was not transmitted, and was considered to be hemic in nature. The abdomen presented point tenderness low in the right lower quadrant. There was no referred tenderness, but rebound tenderness could be elicited over the entire abdomen. There was an enlarged, tender mass occupying the right lower quadrant which was firm. Rather marked rigidity was present. Peristaltic sounds could be heard over the entire abdomen. There was no evidence of distention, and during the course of the examination, the child passed a fair amount of flatus. There was a small amount of fecal material in the rectum which showed no gross evidence of blood. Tenderness was elicited by digital examination high in the rectum, when pressure was directed toward the right lower quadrant.



### Laboratory Findings

Laboratory examination, on admission, showed the total red count to be 1,800,000 with 3.75 Gm. hemoglobin. The white count was 12,800 with a differential of 75 per cent segmented cells, 11 per cent stab cells, 6 per cent juvenile form, 6 per cent lymphocytes, and 2 per cent monocytes. The urine showed no abnormalities, and stool analysis was negative for blood.

### Other Examinations

Roentgenograms of the chest revealed a sharply defined mass at the lateral part of the left apex, extending down to the second interspace, possibly a hemangioma. The remaining portion of the lungs, mediastinum and diaphragms were normal. A scout film of the abdomen showed a flat density on the right which displaced the colon to the left. It had the appearance of a soft tissue mass. A presumptive diagnosis of appendiceal abscess was made and conservative treatment was deemed advisable. A vigorous attempt was made to improve the patient's general physical condition, and in the following twenty-eight hours a total of 1,450 cc of citrated whole blood with additional intravenous fluids were given. Approximately forty-eight hours after admission, the child began to experience nausea, and had some projectile vomiting. There was also distention of the abdomen. The mass was now more sharply defined, more tender, and was movable. Another scout film of the abdomen demonstrated marked distention of the ascending colon, and a few loops of the small intestine. Re-examination of stools then disclosed blood, and a diagnosis of intussusception was made. Operation was carried out shortly thereafter, under pontocaine glucose spinal anesthesia. An ileo-ileal intussusception was found approximately four inches from the ileocecal valve. It was evident gangrene was present. Resection and ileo-ileal anastomosis carried out. Multiple hemangiomas varying in size from a pin-head to 1½ cm. were present in the jejunum and ileum, proximal to the site of anastomosis. The postoperative course was uneventful, except for a minor wound infection which rapidly healed after the evacuation of a small amount of seropurulent material on the seventh postoperative day. The patient was discharged from the hospital on the fifteenth postoperative day, on a high protein diet which was supplemented by iron.

### Pathologic Report

Specimen consisted of a portion of ileum with intussusception. The invaginated portion of the bowel was gangrenous, and on the surface at the fulcrum of the intussuscepted bowel was a lesion which appeared grossly like a hemangioma, measuring 2 cm. in diameter. Several lymph nodes were present in the mesentery. Microscopic sections through the tumor showed large vascular spaces lined by endothelium, which were filled with old blood. The architecture of the bowel was completely disrupted, and was infiltrated with red blood cells. Marked inflammatory reaction was present. The lymph nodes showed areas of hemorrhage.

Diagnosis—Cavernous hemangioma of the ileum; intussusception of ileum with gangrene.

### Summary

A case presentation has been made of a patient who had multiple hemangiomas of the jejunum and the ileum. Acute intussusception, ileo-ileal in character, developed in this patient, resulting in gangrene of the involved bowel. At operation resection was carried out without incident and examination of the surgical specimen revealed a hemangioma at the fulcrum of the invaginated intestine. Whether this is coincidental or whether the tumor acted as the causative agent is entirely problematical.

(From the Somerset Clinic)

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### DISCUSSION

John B. Floyd, Jr., Lexington: We are fortunate to have had the privilege of hearing this excellent case report and review of the literature on the rare subject of intussuscepting hemangioma of the small bowel. This privilege has not been merely hearing the presentation of an unusual subject, but has been the very instructive manner in which Dr. Weddle presented the problem involved in

following the changing of the clinical picture in this sick child.

Intussusception usually demonstrates obstructive signs and symptoms. Intestinal colic must be present before the diagnosis of intestinal obstruction can be made. Wangenstein critically states that intestinal colic consists of abdominal cramps with accompanying peristaltic rushes, which phases were not elicited on admission in this case. Rather the picture was that of a localized appendiceal abscess. Distension and projectile vomiting are later signs of obstruction, while peritoneal irritation, as manifested by abdominal rigidity and guarding, signifies development of strangulation and gangrene of involved viscera.

Dr. Weddle masterfully presented, by steps, the treatment of the picture of appendiceal abscess and paralytic ileus, and as the child developed nausea, and projectile vomiting, with abdominal distension the diagnosis of intestinal obstruction and mechanical ileus was confirmed. The additional finding of melena with the abdominal mass led to the diagnosis of intussusception, and then the necessary abdominal exploration properly was carried out.

Dr. Weddle has covered beautifully the common problem of small intestinal obstruction and intussusception, while giving us a review and case report of great interest. I am grateful to him for the privilege of hearing this paper.

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## PERFORATION OF THE INTERVENTRICULAR SEPTUM FOLLOWING MYOCARDIAL INFARCTION

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Herbert L. Clay, M. D.

LOUISVILLE

### Report of a Case Diagnosed Antemortem

Perforation of the interventricular septum following myocardial infarction is not infrequently found at autopsy. Sager<sup>1</sup>, Weber<sup>2</sup>, and more recently, Fowler and Failey<sup>3</sup> have reviewed the literature quite extensively. Since the latter report, six new cases<sup>4-5-6-7</sup> have been published with the antemortem diagnosis established in two. In this paper no attempt will be made to review the literature, except to point out the similarity between this case and those described by the above authors.

CASE REPORT: J. D., a 73 year old colored male, was admitted to the Louisville General Hospital on September 6, 1948 complaining of substernal pain. The patient had been in good health until thirty-five hours prior to admission, at which time he experienced severe substernal pain radiating to the precordium. After thirty to forty minutes the intensity of the pain had decreased sufficiently to allow the patient to continue his work of feeding hogs. Because of intermittent epigastric discomfort he sought the aid of a private physician, who referred him to the Louisville General Hospital. The patient had been seen one time previously at this hospital, in 1943, for thrombophlebitis, at

which time it was recorded that his cardiac history and physical findings were not significant. There was no notation of any pre-existing hypertension of coronary artery disease.

PHYSICAL EXAMINATION: Blood Pressure, 130/100; Pulse, 120; Temperature, 97.8°F.; Respiration, 16.

The patient was a moderately well developed, senile, colored male, experiencing a minimal amount of pain. There was no clinical evidence of shock or congestive heart failure. His skin was warm and moist, neck veins were not distended, lungs were free from rales, and there was no hepatosplenomegaly, ascites, or pedal edema. The heart was not considered enlarged on physical examination. A "tic-tac" rhythm was noted, as well as a snapping mitral second sound. No murmurs were audible, and no thrills were palpable. There was no calf tenderness, and Hoffman's sign was negative bilaterally. The prostate was enlarged, but not nodular. Reflexes were equal and active; no pathological reflexes were elicited.

LABORATORY DATA: Admission: RBC 3,930,000, Hgb. 12 gm., WBC 17,950, Polys, 88, Lymph. 8, Mono. 4.

DAY OF DEATH: WBC 13,550, Polys. 54, Lymph. 33, Mono. 11, Eos. 2. Non-protein Nitrogen 31 mgm%. Specific Gravity of



Blood 1.056, Specific Gravity of Plasma 1.026, Hematocrit 42.5, Plasma Protein 7.05 grams%, Kahn Positive. Sedimentation Rate 27/60 minutes (Wintrobe). Urinalysis: Albumin, Microscopic: numerous bacteria, rare hyaline cast, 3-4 WBC/H.P.F.

**ELECTROCARDIOGRAMS:** The electrocardiograms on admission showed findings consistent with an antero-septal myocardial infarction. Subsequent electrocardiograms showed an evolution of the S-T segment, T wave and QRS complex abnormalities consistent with antero-septal myocardial infarction. (See figure 1.)

**COURSE:** The patient was put on complete bed rest and given Demerol 100 mgm., Atropine .4 mgm., and Papaverine 100 mgm. The latter was administered every four hours for twenty-one doses, while the Demerol had to be repeated one time for pain. Dicoumoral 300 mgm., was ad-

ministered initially and appropriate amounts thereafter, according to the prothrombin time. The patient's only temperature elevation was to 100°F. orally, which occurred thirty-six hours after admission. On the third hospital day the heart sounds were distant, but no murmurs were heard. Two days later a very loud harsh systolic murmur was audible over the entire precordium, but best heard in the fourth and fifth interspace, just to the left of the mid-sternal line. A systolic thrill was palpable in this area. Except for a drop in blood pressure to 90/70, there was no other apparent change in the patient's clinical status. The diagnosis of a ruptured interventricular septum was made at this time. On the eighth hospital day a rougher quality to the previously described murmur was noted; for the first time the liver was felt, the neck veins appeared distended and a few basal

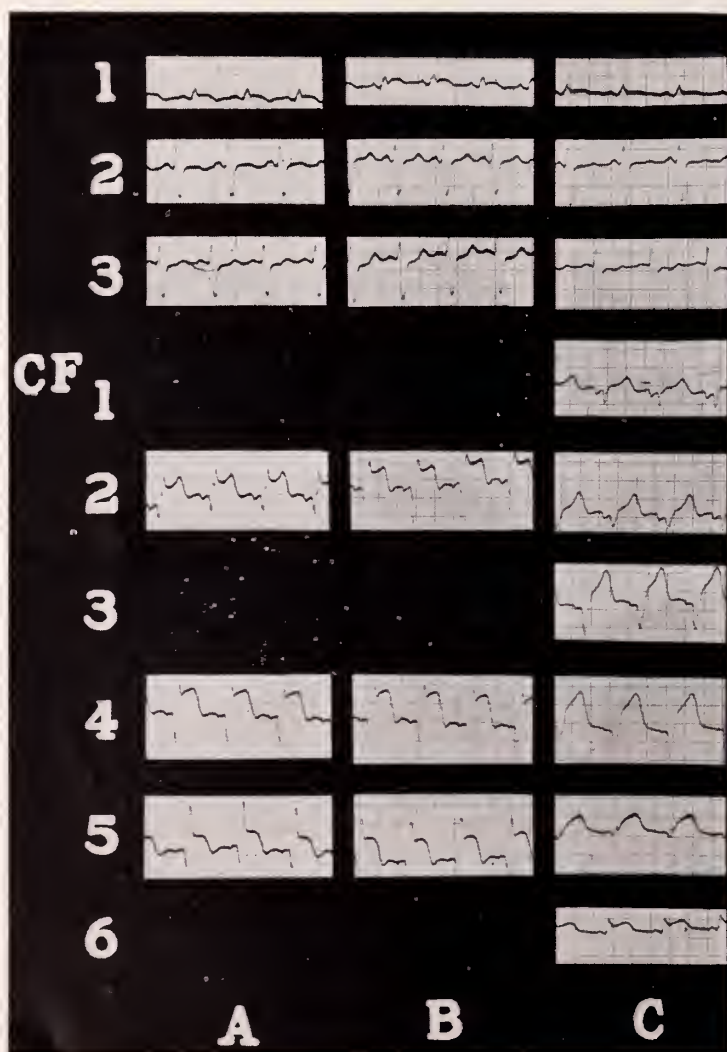


Figure 1. A. Electrocardiogram taken September 7, 1948, forty-eight hours following onset of substernal pain shows ST segment elevation in Lead 1, CF2, CF4 and CF5, ST segment depression in Lead 3, deep Q waves in CF2, CF4, and CF5 and QRS duration of .11 second in limb leads.

B. Electrocardiogram taken September 9, 1948, ninety-six hours following onset of substernal pain and twenty-four hours prior to septal perforation shows further progression of ST segment and Q wave abnormalities.

C. Electrocardiogram taken September 13, 1948, eight days following onset of substernal pain and seventy-two hours after septal perforation shows decrease in abnormality of ST segments.

rales were heard. Blood pressure was recorded as 90/70 and pulse rate at 120. Three hours later the patient was found dead.

#### ANTE-MORTEM DIAGNOSIS:

1. Myocardial infarction due to coronary thrombosis.
2. Rupture of interventricular septum.
3. Passive congestion of lungs and liver.
4. Generalized arteriosclerosis.

#### NECROPSY DIAGNOSIS:

1. Recent infarction of anterior wall of the right and left ventricles and massive infarction of interventricular septum.
2. Coronary atherosclerosis with an obliterating thrombosis of the anterior descending branch of the left coronary artery.
3. Rupture of interventricular septum.
4. Fibrous pericarditis.
5. Arteriosclerosis, generalized.
6. Generalized acute passive congestion.
7. Multiple fresh, small pulmonary infarcts.
8. Softening of the cerebellum, old.
9. Hydrocele, right.
10. Chronic cystitis.
11. Arteriolar nephrosclerosis.
12. Infarction of the right kidney, old.

#### Gross Description of the Heart

(See figure 2 and figure 3.)

The heart measured 12 x 12 x 6 cm. and weighed 560 grams. A scanty amount of fat and a few "soldier's" plaques were noted on the epicardium. The latter presented a finely granular appearance following removal of the fresh adhesions. The anterior surface of the myocardium of the left ventricle, in its lower half, appeared softened. On opening the heart a ruptured trabecula carneae was noted on the extreme apical portion of the left ventricle. Approximately 3 cm. from the apex of the left ventricular cavity there was a small area of ulceration, measuring 1 x 0.6 cm., involving the interventricular septum. This ulcerated area was traced and found to dissect into the lower portion of the right ventricle, demonstrating definite communication between the two ventricular cavities. The interventricular septum varied in thickness from 3 to 6 cm., the thinnest being at the site of rupture. The area of perforation was 3 cm. from the apex on the left ventricular side and 1.8 cm. on the right ventricular surface. The

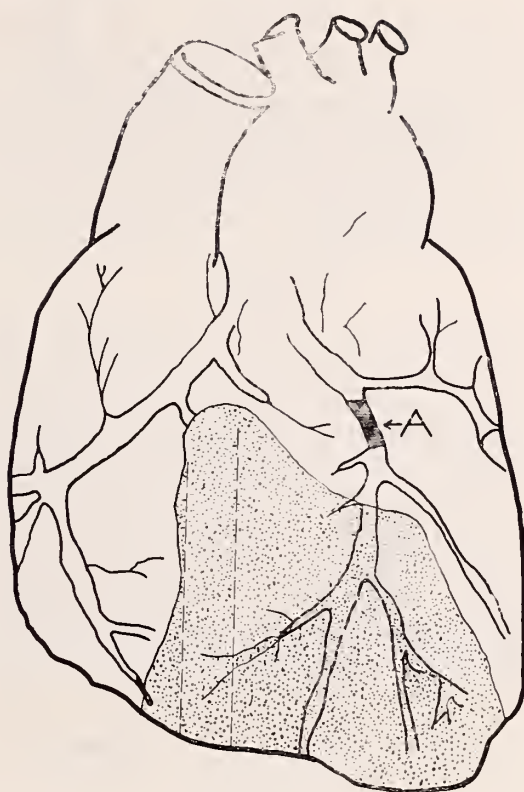


Figure 2. Heart—anterior surface showing extent of infarction in shaded area. Dotted lines represent interventricular septum. Site of obliterating thrombosis of anterior descending branch of left coronary artery shown at A.

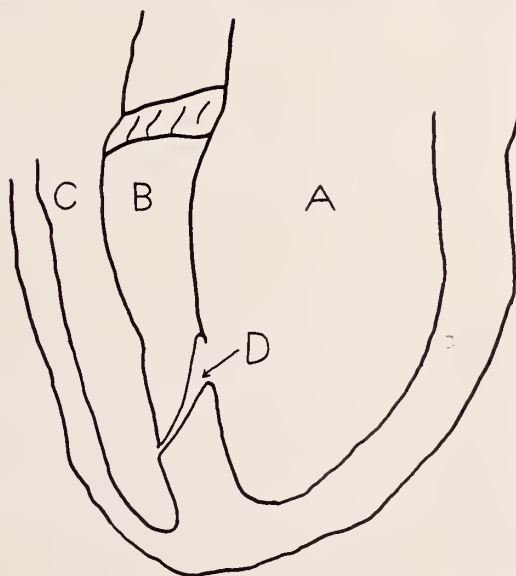


Figure 3. Diagrammatic section of the heart showing location and course of rupture through the interventricular septum. A—Left ventricle, B—Interventricular septum, C—Right ventricle, D—Septal perforation.



infarction involved 80% of the septum, the anterior surface of the lower half of the left ventricle, and a small portion of the anterior wall of the right ventricle. An obturating thrombosis of the anterior descending branch of the left coronary artery was present 2 cm. below the ostium. Numerous atheromatous plaques were visible in the aorta.

### Microscopy

Sections throughout the massive infarction of the left ventricle showed all three layers to be involved. In some areas there was complete necrosis of all tissues, almost to the point of abscess formation. Other areas showed an increase in eosin staining with loss of cell outline and considerable leucocytic and fibroblastic infiltration. Several sections at the point of rupture of the interventricular septum displayed a dissecting oblique tear, the edges of which were coated with fibrin and leukocytes. Sections of the anterior descending branch of the left coronary artery showed severe coronary atherosclerosis with complete obstruction of the lumen by an organizing thrombus.

### Discussion

Sixty-four cases of interventricular septal rupture following myocardial infarction have been found in the literature, eighteen of which have been diagnosed antemortem. As pointed out by Weber<sup>2</sup>, the diagnosis depends on the history of a previous myocardial infarction followed by the sudden appearance of a harsh systolic murmur and thrill in the fourth and fifth interspaces. The intensity depends on the size of the aperture, the smaller the opening, the louder the murmur, and the rougher the thrill. There may be little or no change in the patient's clinical condition at the time of rupture, but if the patient lives long enough there always develops intractable right-sided congestive heart failure that leads to death. Edmonson and Hoxie<sup>9</sup> calculated the average time between infarction and rupture to be 7.4 days; 78% were between the 3rd and 12th day. For this reason they emphasized the importance of extra precautionary measures for keeping patients quiet as possible between the 3rd and 16th days after the attack, especially those that maintain a blood pressure of 140/90 or above after infarction. Thirty-one of the thirty-eight cases reviewed by Fowler and Failey<sup>3</sup> lived less than one month following rupture, and of these, the average sur-

vival time was 6.4 days. Weber<sup>2</sup> pointed out that the site of perforation has its predilection in the lower muscular portion of the septum, while the congenital form is seen in the upper membranous part. The size of the rupture varies from defects admitting only a fine probe to those .3 cm. in diameter, the narrowest defects being the most tortuous.

The patient presented in this report displayed typical features of septal rupture following myocardial infarction as described by the above authors. The perforation occurred five days after infarction and was ushered in by a harsh systolic murmur and thrill, most prominent in the fourth and fifth interspaces. Excluding a slight drop in blood pressure, there was no significant change in the patient's clinical condition at the time of rupture. The electrocardiographic findings were indicative of an acute myocardial infarction involving the anterior wall. (Lead I, Lead III and the CF Leads). With the presence of delayed interventricular conduction and the deep Q waves in CF2, septal involvement was apparent. The patient died in right heart failure nine days after infarction and four days following septal perforation. An autopsy occlusion of the anterior descending branch of the left coronary artery with massive myocardial infarction was found. The site of rupture was close to the apex and consisted of a very narrow tortuous tract.

As brought by many authors the antemortem diagnosis of perforation of the interventricular septum is not difficult. This condition should be differentiated from the following: rupture of a papillary muscle of the left ventricle following myocardial infarction, congenital patency of the interventricular septum, perforation of the septum due to subacute bacterial endocarditis, rupture of a mitral chorda tendinae<sup>3</sup>. Bailey and Hickman<sup>10</sup> stated that rupture of a papillary muscle is quite likely to precipitate an immediate cardiac catastrophe, consisting of acute pulmonary edema, syncope and peripheral circulatory collapse. Diastolic murmurs are common precordium, frequently occurring at the apex<sup>1</sup>. The absence of a history of a recent myocardial infarction with appropriate electrocardiographic findings is the main differentiating point between congenital patency of the interventricular septum and the acquired defect. Perforation of the septum due to subacute bacterial endocarditis is characterized by a fe-

brile course with embolic phenomenon and septicemia. A ruptured mitral chorda tendinea is not associated with myocardial infarction, but presents a picture of insidious or abrupt congestive failure with a systolic, and frequently a diastolic murmur, maximal at the apex. Auricular fibrillation may occur and systolic pulsation of the left atrium may be visualized on fluoroscopy<sup>10</sup>. Scarlini<sup>11</sup> reported a case of rupture of a chronic fibrous aneurysm of the interventricular septum that displayed physical findings of a perforated septum following infarction, however, the absence of electrocardiographic changes characteristic of a recent infarct served to differentiate the former condition from the latter.

### Summary

A typical case of perforation of the interventricular septum following myocardial infarction, diagnosed antemortem, is presented.

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## KENTUCKY CIVIL DEFENSE

The medical and health section of the state civil defense plan is making slow progress according to Dr. Paul M. Crawford, Deputy Director of Health Services for Civil Defense. Slowness in implementation of federal plans is a chief factor; another is lack, on the part of a large section of the public and the medical profession, of appreciation of the fact that there must be local organization for civil defense throughout the state if mobile support is to be furnished to such cities as Louisville. Such local organization is a local responsibility; it does not exist now in many of our cities and counties. In time of disaster state officials will not be able to mobilize non-existent help.

Some progress has been made in training. Second echelon courses for physicians are being offered in 15 cities throughout the state by the K.S.M.A. Committee for Emergency Medical Service. The second echelon course for nurses

will be given in Louisville during March to select nurses from each district in the state. The instruction will be given by nurses who have had a one-week course on Nursing Aspects of Atomic Warfare. Training in radiologic monitoring and biologic defense has been deferred in view of anticipated development by the federal authorities of improved equipment and training courses in its use. Courses in first aid home nursing and for nurses aids are being given by the American Red Cross. The nurses aid courses must be taught in hospitals; in some instances hospital authorities have not been cooperative.

The Kentucky Hospital Association has advised its members to increase stock levels of consumable surgical supplies by 20 per cent; also to study and plan emergency expansion by making the utmost use of existing hospital buildings and planning for emergency use of all suit-

able nearby buildings such as schools. Regular hospital staffs, augmented by volunteers, will be required for operation of these greatly expanded hospitals. Any other professional personnel can best be used if organized into surgical teams, burn teams and shock teams. County medical societies might well take the lead in this, coordinating with local civil defense plans where these exist, and exerting influence through Citizens Health Committees to

initiate and develop such plans where they do not exist.

Lack of local organization on a state-wide basis, and lack of supplies which would be required in huge quantities for the care of casualties are the chief defects of our plan as it exists. This view, with recommendations for corrective action, has been transmitted to the Governor by Dr. Crawford.

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## MEDICINE HAS LOST A FRIEND IN CONGRESS

Senator Virgil M. Chapman was a friend of the medical profession. He was a bitter opponent of governmental interference in the practice of medicine. He was a proponent of constructive health legislation. He was an ardent champion of the Hill-Burton program and was highly instrumental in its passage.

Senator Chapman was a man who stood firmly upon his honest convictions even when such a stand threatened his political security.

In his death the medical profession of our state and of the nation has suffered a severe loss in the Halls of Congress.

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## MEDICAL ECONOMICS COMMITTEE URGES SUPPORT OF BLUE SHIELD

It is the duty of your Medical Economics Committee to interest itself in the economic relationship between the doctor and his patient. The greatly increased costs of medical care has strained this relationship in recent years and has resulted in poor public relations. The social planners have found in the situation a ready-made opportunity to further their schemes for compulsory health insurance.

From the standpoint of the physician this is both unfortunate and unfair. The increased cost of medical care is not due to correspondingly increased charges by physicians, but largely to inflation in general and to inflated costs of hospital operation in particular. Many of the newer drugs and antibiotics, while of great value, are expensive and add to the situation.

Even though medical costs are high the great majority of people could meet them without undue strain if they were budgeted and planned for in advance. The most satisfactory way for the average person to budget his medical care expenses is by prepayment in some good voluntary health insurance plan. Blue

Cross-Blue Shield offers the best bargain to the subscriber since they are non-profit institutions and are able to return a greater percentage of the premium dollar to the subscriber than are commercial companies.

Doctor-sponsored non-profit plans are fully justified in our thinking since the problem is essentially one of the doctor-patient relationship. There has never been any question regarding the individual physician having the right to collect for his services; why should there be objection to physicians collectively providing a means whereby patients can make prepayment for services?

Although the idea of Blue Shield is still comparatively new it has made great strides. Admittedly the Plan has not yet solved all of the problems but with a united profession squarely behind it, the Plan can go much further than it has yet gone. Our own Kentucky Physicians Mutual has made satisfactory progress. In less than a year and a half almost 60,000 Kentuckians have been enrolled. We should not now, however, or perhaps ever, be completely satisfied with it.



Physicians should be interested in continually improving it and strengthening it so that it can become available to every Kentuckian and more completely meet their needs.

Since it is primarily a group plan it is not now available to individuals except for limited periods during community enrollment campaigns. While it is necessary for all such plans to strive continually for large groups, we would like to see a contract developed and made available to the many individuals who desire it. Higher enrollment costs and greater utilization would probably require higher rates than group contracts and poor risks would have to be rejected but there would remain a great number of farmers, self-employed persons and members of groups too small to be eligible at present who could be reached by such a contract.

Our Committee is of the further opinion that as soon as it is economically feasible our Plan should be changed from a cash indemnity basis to a service contract as has already been done in many other states. Under the service contract participating physicians agree to accept the allowance as payment in full for services rendered to subscribers having low incomes. It has been the experience in other states that such a contract is more satisfactory to the subscriber and to the physician. The subscriber likes it because he has nothing further to pay. Physicians like it since they can collect more for services rendered to persons with low incomes.

The threat of compulsory health insurance spurred the profession to sponsor Blue Shield plans. The problem is of

such vital importance in the field of medical economics that such an impetus should not be necessary. Prepaid health insurance, and particularly physician-sponsored plans, is the answer to present day costs of medical care.

Our association several years ago delegated the responsibility for organizing our Blue Shield Plan to a group of physicians headed by Dr. Oscar O. Miller. These men have worked long and hard and have made a great contribution to the medical profession and to the people of Kentucky. They have merited our appreciation and our support.

Your Medical Economics Committee urges every County Medical Society to cooperate to the utmost in supporting our Blue Shield Plan. It urges every physician in Kentucky to become a participating physician. It urges the profession to realize the importance of this effort to the physician and to his patients.

In future issues of The Journal we wish from time to time to bring to your attention other phases of this problem.

#### MEDICAL ECONOMICS COMMITTEE

G. L. Simpson, Greenville, Chairman  
John E. Haynes, Dawson Springs, Member

C. C. Howard, Glasgow, Member

Carl Norfleet, Somerset, Member

**(Editor's Note:** The Journal welcomes the opportunity to print the above editorial and is gratified that the Medical Economics Committee so wholeheartedly cooperates with our Blue Shield Plan.

Other K.S.M.A. Committees are cordially invited to discuss their problems and objectives in our editorial columns.)

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## EARL CARROLL YATES

The anonymity of the editorial page lends itself ideally to the assessment of a friend and an invaluable member of our profession. In paying a tribute to him, we may depart from editorial custom and adopt a text, and what better one than from that great master of morals, the Emperor Marcus Aurelius, "When thou wishest to delight thyself, think of the virtues of those who live with thee," and this brings us to a contemplation of the many excellencies of your friend and our friend, Carroll Yates.

In those early years of struggle for the

formation of a prepaid medical care plan for the State of Kentucky, Carroll Yates became a valued member of this committee on the recommendation of Dr. John Scott. Emerson says that "nothing great was ever achieved without enthusiasm." He brought not only enthusiasm but a thorough going knowledge of existing plans and their organization that was invaluable. He made many able speeches before County Societies and Civic Clubs, against socialized medicine and for prepaid medical care. His untiring efforts and faithful attendance at committee

meetings, and his prepared mind, contributed much to bring the plan to fruition.

But there are many other facets to his character that delighted his friends. He was modest, he never tried to dominate the meeting, but presented his information and cogent arguments in a forceful and logical sequence that won the admiration of his associates. He is a congenial companion; "Hail fellow well met," is one of his dominant traits. One of his scintillating characteristics is his kindness and consideration; this was mirrored in his actions and conversation, and one caught the reflection of superlative and competent services rendered to the sick for a modest compensation. He typifies the best in medicine, and it is such as he, who will save the day for medicine. Surely, "A little leaven leaveneth the whole lump."

He is a fond and indulgent father, affectionate husband and devoted friend, loyal to his convictions, conscientious in the discharge of his many obligations. He has made a fine contribution to organized medicine, to society and to the community in which he resides. Those who had daily contact with him found their lives enriched by the association. And now he is grievously ill, forced into retirement from his committee and civic and professional activities.

What shall we ask for him? We know not; but we would ask much for ourselves; we would ask for the same high courage and fortitude he has always dis-

played; we would ask for the same high regard and esteem that enshrines him in the hearts of his friends; we would ask that we might be privileged to make the same fine contribution to our time and place. The weak man cries for the burden to be lightened, the strong man prays for more strength to carry the load. The last is typical of Carroll Yates. We would assure him that his friends will go every step of the way with him and that he is not alone. There is no barrier to thought; it leaps time and space, and soul may commune with soul.

"Let the soul be assured," says Emerson, "that somewhere in the universe it should rejoin its friend, and it would be content and cheerful alone for a thousand years."

One of the fine compensations in life are the friendships we are privileged to make, especially those friendships that are enduring and that we can treat in the roughest kind of way. These are the friendships that Carroll Yates has made throughout a successful career. His has been a rich and full life; a life full of service. Emblazoned on his heart and conscience is that noblest of all mottoes, "*Ich Dien, I serve.*"

(Editor's Note: We are happy to have the privilege of printing this splendid, highly deserved tribute to Dr. Yates. The author requested that it be printed anonymously. This is most fitting since he has spoken not only for himself but for the entire host of Dr. Yates' friends.)

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**Two new methods developed by Army** research to simplify and improve the treatment of extensive radiation burns were revealed recently.

One treatment, called the "open" method, is carried out without the use of any type of dressing. The other type of treatment requires a standardized pressure dressing.

Both treatments were described by Colonel William S. Stone, Commandant of the Army Medical Graduate School at Washington, D. C.

Colonel Stone described the open treatment, new in medical circles, as simply exposing the burned surface to warm, dry air, using no medication. A dry crust forms in 24 hours, after which a high calorie nutritious diet is supplied. Infection is prevented by antibiotic drugs. A

minimum of nursing care is needed after formation of the dry crust.

The pressure method, he said, is more applicable to extensive burns involving more than 20 per cent of the body surface. In this treatment a new specially constructed dressing is used which requires no change until second degree burns are healed or third degree burns are ready for skin grafting.

Colonel Stone emphasized that no medication is used on the surface of burns in either method. It has been found unnecessary to have a layer of vaseline gauze against the burn surface. Dry gauze does not adhere and no difficulty is encountered in removing the dressing after 14 to 21 days, but it should not be changed until the patient is ready for skin grafting, he pointed out.





## EDITORIAL COMMENTS



**A new intramedullary pin plus improved technic** is reported by Major General R. W. Bliss, Army Surgeon General, to be giving uniformly satisfactory results in fractures of the femur in Tokyo Army Hospital.

As with similar pins, the need for a cast is eliminated and the patient can bear weight on the leg almost immediately. Present Army practice requires two weeks rest. The patient is then permitted, using crutches, to exercise and do some light work.

Dr. Bliss states that the new bone pin promotes faster growth of new bone tissue, permits earlier fixation of the bone, and avoids joint stiffness and muscular atrophy associated with immobilization of the leg in a cast.

The patient's ability to walk and to care for himself early in convalescence is a potent morale factor, and represents considerable gain to the Army in terms of medical manpower and hospital space.

**Disagreement between V. A. Administrator, Carl R. Gray, Jr., and Chief Medical Director, Dr. Paul B. Magnuson**, is widely reported to have been due to different concepts of hospital administration. Dr. Magnuson feels that hospitals should be directly under the medical department. Mr. Gray seems convinced that doctors are not good administrators and that their abilities should be utilized in rendering medical care to patients.

Following acceptance of Dr. Magnuson's resignation, which was tendered over two years ago, Mr. Gray appointed Vice-Admiral Joel T. Boone to the position. Dr. Magnuson has strived to elevate the standard of medical care in V. A. hospitals and

it is hoped that Vice-Admiral Boone will continue many of the policies instituted by his predecessor.

Vice-Admiral Boone is considered to be a well-informed and highly efficient medical administrator.

**A rather unusual debate was recently held in Massachusetts between two state prison inmates and two members of the Harvard College Council.** The subject was, "Resolved: That the American People Should Support the Welfare State." The prisoners took the negative side and won. Who else could have spoken with greater authority than recipients of 100% governmental security with complete loss of personal freedom.

**In accordance with the by-laws the Council of Kentucky State Medical Association** has instructed the Headquarters office to classify as delinquent and drop from membership all members who have not paid their 1951 dues by April 1.

Physicians cannot afford to lose their identity with organized medicine. Unfortunately, not all of the benefits of membership in the county and state societies are tangible, but if there were no other advantages than to be eligible for the medico-legal defense services provided by the association, to be eligible for malpractice insurance by the commercial companies, and to receive the Journal, the annual dues would be a good investment.

If you should be one of those of our highly valued members who have inadvertently overlooked this matter and you do not wish to remain delinquent, you are urged to make your remittance to your county medical society secretary.

# ORGANIZATION SECTION

## FIRST COUNTY SOCIETY OFFICERS CONFERENCE PLEASES OFFICIALS

### Ninety-Nine Attend March 1 Meeting

A total of 99 county medical society and state officers officially registered for the First Annual County Society Officers Conference, sponsored by the Kentucky State Medical Association in Louisville, March 1, 1951.

The reaction of various members of the official family of the Association and county society officers, obtained after the meeting, was most enthusiastic. All felt that it was a very profitable conference to all concerned, and that it should be developed as an annual effort of the Association.

The attendance was highly satisfactory to the officials. While 99 officially registered, it was learned that some were present who did not register. The Councilors interviewed felt the individual Councilor District conferences were most worthwhile, as they offered opportunities to consider problems and projects for their District.

Sam A. Overstreet, M. D., President of the Association, presided at the morning session of the conference. After a welcome of the county society officials by Bruce Underwood, M. D., Secretary and General Manager of the Association, Dr. Overstreet spoke on the plans for the Centennial celebration, which is to be held in Louisville, October 2, 3 and 4.

Following Dr. Overstreet, P. M. Crawford, M. D., Deputy Director of Medical Services in the State Civilian Defense organization, explained what had been done by his office and what some of the plans for the future are.

The organization of the Kentucky Procurement Committee for Military Service was explained by A. Clayton McCarty, M. D., Louisville, Chairman of that committee. Problems confronting the committee were explained. Dr. McCarty closed his talk by asking the co-operation of county society officials when called upon to provide essential information on procurement matters.

The legislative program adopted by the House of Delegates at the 1950 Annual Session was discussed by Dr. Underwood. He explained how the legislative policy of the Association would be determined, and what would be undertaken in the immediate future. He also dwelt on some of the problems faced in the operation of the Department of Health.

Legislative techniques were discussed by Charles S. Nelson, Executive Secretary of the Ohio State Medical Association. Mr. Nelson spoke out of the experience of fifteen years in promoting health legislation, and gave the group some valuable suggestions.

The importance and responsibility of the county society in both the state and national legislative picture, with respect to the enactment of good health legislation, were discussed by Joseph S. Lawrence, M. D., Director of the A.M.A. Washington office. Dr. Lawrence told the conference that the legislative program of organized medicine would succeed or fail as the result of individual and local effort.

The afternoon session was presided over by Clark Bailey, M. D., Harlan, President-Elect of the Kentucky State Medical Association. He was introduced by Dr. Overstreet, at the conclusion of the luncheon.

The first afternoon speaker was Elmer L. Henderson, M. D., Louisville, A.M.A. President. Dr. Henderson brought greetings from the American Medical Association and introduced the luncheon speaker, George F. Lull, M. D., Secretary and General Manager of the A.M.A.

Dr. Lull told the county officers some of the many and varied services the American Medical Association offered the individual physician and the county society. He stressed the need of a strong local county medical society organization.

R. Haynes Barr, M. D., Owensboro, Chairman of the Education Subcommittee, talked on the public relations program of the State Association. Dr. Barr explained the objectives of the State Public Relations Program, and urged the county medical societies to develop and carry out a program of their own.

Public relations in Indiana was described by Ray Smith, Indianapolis, Executive Secretary of the Indiana State Medical Association. Many of the county officials felt that they would be able to adopt some of the program the Indiana Association had carried out so effectively, in their own county organizations.

C. C. Howard, M. D., Glasgow, Chairman of the Council, was the moderator for the question-and-answer period following the morning session. Hugh L. Houston, M. D., Murray, Speaker of the House of Delegates, moderated the discussion period at the close of the afternoon session. No discussion was held following the individual talks, but those in attendance



were able to ask their questions during question and answer periods.

The individual Councilor District conferences were held just before the luncheon. Rooms were provided free of charge by the hotel, for these Councilors to meet the county society officers of their district, for a 30-minute session.

### **Emergency Medical Service Groups Urged For All Counties**

Every county medical society in the state will be asked to appoint an Emergency Medical Service Committee, it was decided at a meeting of the Emergency Medical Service Committee of the Kentucky State Medical Association, February 28, Pat R. Imes, M. D., Louisville, Chairman of the state committee, has announced.

"Such county organizations would greatly facilitate the dissemination of information regarding the medical aspects of Civilian Defense, and most important, to organize medical personnel resources for the actual caring for casualties resulting from a disaster," Dr. Imes said.

Following the appointment of each county committee, the county society is asked to forward the names of the personnel of each committee, together with the name of the chairman, to the Headquarters office at 620 South Third Street, Louisville, Kentucky.

Other members of the committee, in addition to Dr. Imes, are Guthrie Y. Graves, M. D., Bowling Green; Orion L. Higdon, M. D., Paducah; Francis M. Massie, M. D., Lexington; Leland E. Payton, M. D., Lynch; and W. Mountjoy Savage, M. D., Maysville.

### **Pediatricians to Hold Annual State Meeting April 26, 1951**

The Kentucky Society for the Advancement of Pediatrics will hold its second annual meeting at the Pendennis Club in Louisville, Thursday, April 26, 1951, Harry Andrews, M. D., Louisville, announced.

The meeting will open with an afternoon session at 1:30. Dinner will be served at 6:30, and will be followed by the evening session. The society cordially invites Kentucky physicians interested in pediatrics to become members of the society.

The afternoon meeting will feature a round-table discussion on "The Lymphomas," by Peter Vogel, M. D., Clinical Pathologist, New York City; and Warren Wheeler, M. D., Professor of Pediatrics, Children's Hospital, Columbus, Ohio. Marion F. Beard, M. D., Louisville, Assistant Clinical Professor of Medicine,

School of Medicine, University of Louisville, will be the moderator.

The evening session will also be a round-table discussion on the subject of "Rh Problems." The same physicians who participated in the afternoon session will be the principals in the evening session.

### **Anesthesiologists Expect 200 at Louisville Meet, April 20-21**

More than 200 physicians are expected to attend the annual meeting of the Southern Society of Anesthesiologists, April 20-21 in the Brown Hotel in Louisville, Kentucky.

Kentuckians will present two of the 16 papers at the meeting. "Clinical Experience with 26-Gauge Spinal Needles" will be given by Catherine K. Owen, M. D., John J. Owen, M. D., Warren F. Sergeant, M. D., and John W. McGowan, M. D., all of Lexington. A paper on "Paraplegia Following Spinal Anesthesia," will be presented by Ephraim Roseman, M. D., Hollis Johnson, M. D., Walden R. Smith, M. D., and Robert P. Bergner, M. D., of Louisville.

Other features of the meeting include a cocktail party and buffet supper, Friday evening, and a round table discussion at luncheon on the same day.

German Dillon, M. D., Louisville, President of the Kentucky Society of Anesthesiologists, and Fred Williams, M. D., Louisville, are the managing co-chairmen for the arrangements of the annual session. Members of the Kentucky State Medical Association are cordially invited to this clinical program, which will include sixteen papers, Drs. Dillon and Williams said.

### **Local Society of Student A.M.A. to Draft Constitution**

The University of Louisville Student Medical Society, which has a membership of more than 120, voted to accept the Student A.M.A. Constitution at its first meeting held late in February.

Charles J. McGaff, Louisville, sophomore, was elected as temporary president of the local organization. The group's next step, according to McGaff, is framing and adopting a constitution. When this has been done permanent officers will be chosen.

A local advisory committee is provided for by the Student A.M.A. Constitution. This committee, which is now in the process of being set up, is composed of the Dean of the School of Medicine (or his appointed representative), two faculty members selected by the students, and representatives of the county medical society and the State Medical Association.

By accepting the Student A.M.A. Constitution before March 1, 1951, members of the local society became charter members of the Student A.M.A. The national organization was formed late in December, 1950. John Hummel, Williamsburg, a Junior, represented the local school at the December organizational session.

### **Pediatrics Course Starting May 3 to Have Eight Sessions**

A postgraduate course in Pediatrics will be held at the Children's Hospital in Louisville, starting May 3, 1951 and running for eight consecutive Thursdays, through June 21, 1951.

The course, which runs for three hours each day, starting at 9:00 A. M., is held under the auspices of the University of Louisville, School of Medicine, and in cooperation with the Kentucky State Medical Association.

An invitation is extended to all Kentucky physicians to attend this course. Physicians from adjoining states will also be invited to take part. Inquiries for additional information should be directed to W. W. Nicholson, M. D., 1974 Douglass Blvd., Louisville 5, Kentucky.

The programs for the May 3, 10, 17, and 24 sessions follow:

#### **May 3, 1951**

- 9-10 Modern Concepts in Infant Feeding  
.....James W. Bruce, M. D.
- 10-11 Staff Conference  
.....Leonard T. Davidson, M. D.  
Discussion.....John B. Larson, M. D.
- 11-12 Surgery of the G. I. Tract in the New-born.....Charles Maguire, M. D.

#### **May 10, 1951**

- 9-10 Rheumatic Fever..Joseph A. Little, M. D.
- 10-11 Staff Conference  
.....Leonard T. Davidson, M. D.  
Discussion.....Margaret Limper M. D.
- 11-12 Surgery of Congenital Heart Disease  
.....W. Burford Davis, M. D.

#### **May 17, 1951**

- 9-10 Influenzal Meningitis  
.....Cathryn C. Handelman, M. D.
- 10-11 Staff Conference  
.....Leonard T. Davidson, M. D.  
Discussion.....J. J. Glaboff, M. D.
- 11-12 Subdural Effusion  
.....Richard P. Schmidt, M. D.  
H. Lester Reed, M. D.

#### **May 24, 1951**

- 9-10 Pediatric Psychiatry  
.....Henry H. Work, M. D.

#### **10-11 Staff Conference**

.....Leonard T. Davidson, M. D.  
Discussion.....Owen S. Ogden, M. D.

#### **11-12 X-Ray Conference**

.....Alfred O. Miller, M. D.

Programs for May 31, June 7, 14, and 21, will be carried in the May issue of this Journal.

### **Surgeons to Hear Four Kentuckians at Hollywood Session**

Four members of the Kentucky State Medical Association are scheduled to participate in the program of the Nineteenth Graduate Assembly, sponsored by the Southeastern Surgical Congress, April 11, 12, 13 and 14, 1951, at the Hollywood Beach Hotel, Hollywood, Florida.

C. C. Howard, M. D., Glasgow, Chairman of the K.S.M.A. Council, and President of the Congress, is one the the speakers. The subject of Dr. Howard's paper is "Accidents and a Proposed Program of Prevention."

Other Kentuckians to speak are Elmer L. Henderson, M. D., Louisville, "1951 - Medicine's First Year of Grace", Herman Mahaffey, M. D., Louisville, "Fibrosarcoma of Ileum", and Clyde C. Sparks, M. D., Ashland, "Common Benign Breast Lesions."

B. T. Beasley, M. D., 701 Hurt Building, Atlanta 3, Georgia, will furnish further information on request.

### **Industrial Health Congress Hears Louisville Physician Feb. 26**

The eleventh annual Congress on Industrial Health, sponsored by the Council on Industrial Health of the American Medical Association, was held February 26, 27, and 28, 1951, in Atlanta, Georgia.

Gracie R. Rowntree, M. D., Louisville, Associate Professor in Preventive Medicine, Public Health, and Chief, Section of Industrial Medicine, University of Louisville, gave a paper at the meeting, entitled, "Expanding Industrial Health Requires Qualified Physicians."

The conference, attended by physicians interested in industrial health from all over the United States and foreign countries, was held in the South for the first time because of the rapid growth of industry in this region.

Highlights of the meeting included a discussion of the place of industrial medicine in Civilian Defense, measures necessary to insure high productive capacity from health workers, and a roundtable session called, "How the South Meets Its Problems."



### **Hospital Association to Meet in Louisville April 10-12, 1951**

The Kentucky Hospital Association will hold its annual meeting in the Kentucky Hotel, April 10, 11, and 12, William A. Wyckoff, Glasgow, President of the association, has announced.

Members of the Kentucky State Medical Association will be welcome, Mr. Wyckoff said. Of particular interest to the physicians will be the speaker at the annual dinner, Frank F. Selfridge, President of the Highland Park Hospital Foundation, Highland Park, Illinois. Mr. Selfridge will speak on "The Responsibility of Governing Boards for Maintaining Medical Standards in Hospitals."

### **New 38-Minute Film Is Available to Physician Groups**

"Here's Health—The American Way," is the title of a new film released to the Kentucky State Medical Association by the American Medical Association for use only before physician groups.

This new print is a 16 millimeter film and runs for thirty-eight minutes. The film was produced by Louis de Rochemont, and deals with the subject of health progress.

Any county medical society or other medical group that would like to use this film before a physician audience should make their request known to the Headquarters office as far in advance of the time they expect to use the film as possible.

According to George F. Lull, M. D., Secretary and General Manager of the A.M.A., it will not be possible to show this film before lay groups before early 1952.

### **Dr. Henderson Elected President of Education Foundation**

Elmer L. Henderson, M. D., Louisville, Kentucky, was elected as the first president of the new American Medical Education Foundation, at a meeting of the corporation held in Chicago, February 23, 1951.

The Foundation was created by the American Medical Association for the purpose of raising funds from private sources to aid medical schools in this country and avoid federal subsidiation.

The A.M.A. contributed \$500,000.00 to this fund; the California Medical Association has given \$100,000.00; and one medical publication has subscribed \$10,000.00. Each physician is asked to contribute individually to the Foundation. Donors may designate the medical school that is to receive the contribution.

Louis H. Bauer, M. D., Chairman of the A. M. A. Board of Trustees, made the following statement, "The A.M.A. will absorb all the expenses of the Foundation so that none of the money contributed will be used to meet overhead. Every dollar contributed will go to the medical schools with no strings attached."

### **KENTUCKIANS TAKE PART IN SIXTH CONFERENCE ON RURAL HEALTH**

#### **600 Farm, Medical Leaders Attend**

Rural communities are moving toward a solution of community health problems with encouraging speed, it was demonstrated at the A.M.A. sponsored National Conference on Rural Health at Memphis, Tennessee, February 22-24.

A number of Kentuckians were among over 600 medical and farm leaders attending the meeting conducted by the Committee on Rural Health of which F. S. Crockett, M. D., Lafayette, Indiana, is Chairman.

Three Kentuckians participated in the program. Mrs. Shelby Carr, wife of a Richmond physician, spoke on "Using Wisely the Things That are Available." D. G. Miller, Jr., M. D., Morgantown, a member of the A.M.A. Committee on Rural Health, took part in a panel discussion.

Others taking part in the program were Elmer L. Henderson, M. D., Louisville, A.M.A. President; Haven Emerson, M. D., New York; Aubrey Gates, Field Director for the Rural Health Committee; Dean S. Luce, M. D., Canton, Massachusetts, the "General Practitioner of 1950"; George Bond, M. D., Bat Cave, North Carolina; Edmon K. Yantes, M. D., Wilmington, Ohio; and George F. Lull, M. D., Secretary and General Manager of the A.M.A.

Mrs. Carr, illustrating her lecture with colored slides, told how she and a group of health volunteers in Madison County used the facilities at hand to improve health conditions in isolated one-room county schools.

"Too often we feel that we cannot do things in our communities because we don't have money—big money," she said. "We have come to think that a project cannot succeed without the backing of the Sloan or Kellogg Foundation or the government. Yet, our forefathers carved a great nation without money. How? By using wisely the things that were available."

The yardstick which Mrs. Carr and her group of workers used was: (1) Help others help themselves. (2) Take things that are available to where they are needed. (3) Do not ask for money. (4) Keep the community informed of needs and plans for meeting these needs.

Dr. Miller, who practices at Morgantown, played the part of the physician in a one-doctor Arkansas community in an unrehearsed skit. Other participants included the county agent, farm bureau president, home demonstration agent, milk inspector, extension worker, president of the local Grange and a P.T.A. representative.

In an entertaining, humorous, but most effective way, the skit demonstrated how a community health council can be formed and what a community can accomplish.

Dr. Henderson, who spoke at the luncheon meeting on the last day of the conference, assured the medical and farm leaders of A.M.A. support. He stated that the conference proves the American people can still handle their own health problems better than the government.

"Local health conferences," Dr. Henderson said, "Will bring to the communities a realistic approach to the vital problems of health care." He cited the progress in medicine which has given physicians the ability to provide more health care than ever before.

One of the high points of the conference was the address delivered by Dr. Emerson at the evening meeting Friday. Dr. Emerson, a former Professor of Public Health and a member of the New York City Board of Health, stated that intelligent spending for prevention of disease will greatly reduce the total expense of medical care.

In pointing out the need for adequate public health services, Dr. Emerson stated, "More doctors and more hospitals will not prevent sickness from preventable and occupational diseases." He stated that public health is much cheaper than the care of the sick.

He said the health department is the pulpit from which the medical profession and medical science can tell the story of medical services without being questioned.

Communities must accept the responsibility for nutrition, environmental sanitation and immunization against infectious diseases if good health is to be obtained, Mr. Gates told the conference. Mr. Gates said, "Unless a community accepts these responsibilities it will not have good health no matter how much and how good the medical care is."

Dr. Yantes gave a report of the most effective operation of the rural health movement in the rural community of Wilmington, Ohio. Dr. Yantes explained how his council was formed and how it operated.

He pointed out the necessity of getting the proper leadership in the community, enlisting the various community organizations and hav-

ing a worthwhile program if the health council is to succeed.

Dr. Crockett, the Chairman of the A.M.A. Committee on Rural Health and one of the founders of the rural health movement, in his opening remarks to the conference paid tribute to the cooperative spirit shown by farm and civic leaders and the medical profession in working out programs for adequate medical care. "This has not been developed as a doctor's plan," Dr. Crockett said. "It has been developed in an atmosphere of mutual trust and good will and of neighbors meeting to solve community problems in which we all have equal interest—none of us entering into this has claimed a preferred or dominant position."

Dr. Bond, who played a leading role in the film made by the Reader's Digest entitled, "M.D.—The U. S. Doctor," told how this community in the North Carolina mountains, with a population of about 6,000, met and solved its medical problems. "People must learn that their doctor can be a complete family doctor although his practice does not permit him to travel a great distance or to be very long out of touch with the community hospital," he said. "Our people must learn that the best medical care they can receive will be in the local medical center."

### General Practice Award

The Academy of General Practice of Kentucky is offering an award for the best paper submitted on any subject pertaining to general practice. Dr. D. G. Miller, Jr., Morgantown, Kentucky, Secretary-Treasurer of the Kentucky Academy of General Practice, has supplied the rules governing the award as follows:

1. Any general practitioner in Kentucky may submit a paper based on original work he has done as a general practitioner.
2. Paper to be typewritten, double spaced, on one side of plain white paper, bearing no name, sealed envelope to be clipped to paper containing name and address of physician submitting the paper.
3. Paper must be submitted before July. Send to Academy office in Morgantown, Kentucky.
4. May be on any subject the writer wishes.
5. Will be judged by three University of Cincinnati physicians.
6. Award will be based on originality and practicability of research.



### Kentuckians to Attend Yale Institute

Hugh L. Houston, M. D., Speaker of the House of Delegates of the Kentucky State Medical Association, G. R. Jones, M. D., Assistant Director of Preventive Medical Services of the State Department of Health, and Thomas Crume, M. D., member of the Board of Directors of the Owensboro Heart Association, have been chosen by the Kentucky Heart Association and the State Department of Health to attend a heart disease Institute at Yale University April 2-13, 1951.

The Institute will be held in the Department of Pediatrics, Grace-New Haven Community Hospital, New Haven, Connecticut, and is tuition-free with all traveling and living expenses paid.

### Doctor's Day Celebration Planned

The Woman's Auxiliary of the Jefferson County Medical Society has sent out over 600 invitations to the physicians of Jefferson County, inviting them to the Doctor's Ball, commemorating the annual Doctor's Day.

The ball will get under way with a dinner at 6:30 P. M., and will be held April 14, 1951, in the Crystal Ballroom of the Brown. The announcement was made by Mrs. W. Duncan Crosby, Chairman of the Woman's Auxiliary.

### New V. A. Medical Chief Takes Office

Vice Admiral Joel T. Boone, (MC) U. S. Navy, retired, became Chief Medical Director of the Veterans Administration February 28. He succeeds Paul B. Magnuson, M. D., who left the directorship after a controversy with Carl R. Ray, Jr., V. A. administrator, over medical policies.

Vice Admiral Boone, in taking the oath of office, said, "I shall do everything within my power to see to it that the V.A.'s long-established policy of the best medical care for veterans remains strong...positive....and progressively better."

### Hospital Offers Postgraduate School

The Michael Reese Hospital Postgraduate School, Chicago, is offering two one-week courses in early April. One course is in "Clinical Dermatology—Refresher Course in Diseases of the Skin for General Practitioners," from April 2 to April 7, 1951. The other is in "Surgery—Indications, Pre- and Post-Operative Care," from April 9 to April 14, 1951. For further information, address Samuel Soskin, M. D., Dean, 29th St. & Ellis Ave., Chicago 16, Illinois.

## Pertinent Paragraphs

**Members of the Woman's Auxiliary to the Kentucky State Medical Association** have been asked to commemorate Doctor's Day, April 13, 1951, on the county auxiliary level. This celebration will be observed by social events, appropriate editorials and radio programs, officials of the State Woman's Auxiliary said.

**The third edition of the Kentucky Medical Directory**, corrected to February 15, 1951, was mailed to the physicians of the state on March 15. If you discover any errors in this directory, your kindness in making them known to the Headquarters Office will be appreciated.

**County medical societies interested in having health exhibits at fairs and public gatherings** should write the Headquarters Office for the new pamphlet entitled, "Health Exhibits for Fairs and Expositions." This booklet, printed by the American Medical Association, will be found to contain a wealth of information and is available upon request.

**The University of Louisville School of Medicine** has been awarded \$7,700.00 for polio research, the first grant ever given an institution in Kentucky by the National Foundation for Infantile Paralysis. The research will be conducted by Dr. Alex J. Steigman, Professor of Child Health at the University of Louisville School of Medicine.

**R. Arnold Griswold, M. D., Head of the Department of Surgery of the University of Louisville School of Medicine**, gave a paper March 14 before the George Washington University School of Medicine. Dr. Griswold spoke on "Indications for Surgery in Peptic Ulcer."

**The American Nurses Association** has revealed that, of a total of 506,000 registered nurses, 205,000 of these are not practicing. The Association, together with the A.M.A. and the Army, is promoting a campaign to get these retired nurses back into service, thus releasing younger ones for military duty.

**Joseph C. Hinsey, M. D., Dean of Cornell Medical School**, speaking for the Association of Medical Colleges has demanded that steps be taken to retain the medical program of the

V.A. under medical direction. He said that disagreements over the program over the last two years "threaten the continued existence of the present excellent medical program." He made it clear that the Association is supporting wholeheartedly Vice Admiral Joel T. Boone, who succeeds Paul Magnuson, M. D., as V. A. medical director.

The rumor that the supply of ACTH is dwindling has been denounced by the maker of the drug. When production started, it took a little while to fill the orders placed at that time, but the supply is now enough for government requirements and civilian use.

The American Nurses Association has appealed to the Wage Stabilization Board for development of policies to support efforts to relieve the critical shortage in the profession. Adjustment of inequities, both in various institutions and in comparison with other occupations, as to salaries, and the safe-guarding of existing collective bargaining agreements, are pointed out as being major contributions to the drastic deficit in the nursing profession.

The American Goiter Association has announced that its 1951 annual meeting will be held May 24, 25, and 26, 1951, in the Deshler-Wallick Hotel at Columbus, Ohio. The program for the meeting will consist of discussions of goiter and other diseases of the thyroid gland, dry clinics and demonstrations.

In order to arrive at an estimate of the best distance from the screen to view television, the A.M.A. Journal submitted the question to "three medical authorities." The unanimous decision was that a distance of about 10 feet from small or moderate screens is the most desirable for eye-comfort.

The 47th Annual Congress on Medical Education and Licensure, sponsored by the A.M.A. Council on Medical Education and Hospitals, the Advisory Board for Medical Specialties and the Federation of State Medical Boards of the United States, met at Chicago, February 11-13, 1951. Problems arising from the mobilization of medical manpower were the chief topic of discussion.

## KENTUCKY PROCUREMENT COMMITTEE NEWS

by

A. Clayton McCarty, M. D., Chairman

### Air Force to Offer Limited Number Of Reserve Commissions

The Air Force will accept a limited number of applications from physicians in Priority I for reserve commissions, it recently announced.

Applications for service with the Air Force for men in Priority I were discontinued last November. The number of applications to be commissioned now will depend upon the expansion of the Air Force.

misplaced it, please contact the Headquarters Office immediately.

As has been previously pointed out, the committee found it necessary to obtain this information in order to comply with the system of the National Advisory Committee set up under Public Law 779. The Kentucky Procurement Committee will be able to serve you better with this information.

### Physicians Urged to Return Form To Procurement Committee

The response of the majority of physicians of Kentucky in completing the form requesting additional information, and returning it to the Kentucky Procurement Committee for Military Service, is appreciated by the committee.

To those physicians who have not sent in their forms, your cooperation is sincerely requested. If you did not receive a form or have

### State Quota For April Medical Officer Call Is Seven

Kentucky's quota of physicians for the April call of the Army medical reserve officers will be seven, Col. Owen R. Durham, of the Kentucky Military District of the Second Army area, has announced.

The Defense Department has authorized the Army to call up 300 medical officers and 100 dental officers, out of men classified as Priority I under Public Law 779. The total number of men to be called from the Second Army



area, of which Kentucky is a part, is 47 men, Col. Durham said.

The officers will be given at least 30 days in which to close out personal and business affairs, unless they wish to report at an earlier date.

This is the first group of medical and dental officers ordered into active military service by the Army since December 26, 1950, when 890 medical and 850 dental officers were ordered to active service.

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### **Heavy Cut in Hospital Personnel Forecast for Next Year**

The National Advisory Committee to Selective Service has estimated that the eligibility of physicians to be drafted will bring a heavy cut in the residencies of all hospitals, according to Joseph S. Lawrence, M. D., Director of the A.M.A. Washington Office.

The Committee's Information Bulletin (Vol. 1, No. 4) carried the following statement, "An over-all estimate of the number of individuals who should be available to serve as hospital residents next year indicates that the total will probably be about 75 percent of the residents presently serving in hospitals."

Hospital administrators are urged to take this fact into consideration when planning house appointments.

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### **V. A. Hospitalizes Rehabilitation Cases**

Plans have been announced by the Department of Defense and the Veterans Administration to hospitalize rehabilitation patients in V. A. hospitals on the same basis as veterans with service-connected disabilities.

The new plan will pertain to military patients whose disabilities exclude them from probable return to active service. It speeds transfers and reduces the national demand for critical medical personnel by having patients located in one organization rather than separating them into Army, Navy, and Air Force groups.

The plan will continue the V.A.'s present hospital organization and will provide for the care of veterans after the present emergency is ended.

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### **Changing Conditions Force Agencies To Alter Directives**

This department would like to remind its readers that from time to time information reported here may be in seeming conflict with material previously published in the Journal or gleaned from other sources.

World conditions are changing rather rapidly. As the agencies of the government meet these changes, it is necessary to alter directives.

A span of approximately three weeks' time exists between our dead line and the time you first receive the Journal. It occasionally happens, therefore, that we will report on a directive for a government agency and the directive is changed by the time you receive your Journal.

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### **Response of Doctors Commended By Procurement Committee**

The Kentucky Procurement Committee is glad to commend the physicians of Priority I who responded to the committee's letter pointing out the advantages of obtaining a commission as a medical officer in the Army reserve at this time.

To the physicians in Priority I and Priority II who have not as yet applied for commissions in the reserve, the committee urges their consideration of this matter at once.

As pointed out in the letter to men in Priorities I and II, getting a commission at this time does not mean that the reservist will be called any sooner but it does mean that he will (1) have an opportunity to do the type of work he wants; (2) have some choice in the service he selects; (3) be eligible for the \$100 per month bonus.

Selective Service officials in Washington have told the state committees that, while it may not be necessary to draft physicians as soon as originally announced, it is going ahead with its original plans.

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### **All Physicians Asked to Return Procurement Questionnaires**

Some confusion has developed over whom should fill out and return the new questionnaire the physicians of Kentucky received March 15 from the Kentucky Procurement Committee.

The committee wishes to make it clear that every doctor is expected to complete and return this form (Form NSRB-504) at your very earliest convenience.

It is not only important to have the data on men covered by Public Law 779 but all other physicians as well, as this is a part of a national medical manpower survey.

The information will be used in connection with matters of procurement, civilian defense and other phases that pertain to the defense effort.

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## *President's Page*

Little thought has been given to our responsibility in effecting a plan of civil defense in case of war. We are not an industrial state but our cities are strategic centers vulnerable to attack. We do not anticipate a war in the near future but lethargy, indifference and unpreparedness are dangerous habits. We must be alert because if calamity should strike, we as a profession would be held to blame for deaths. It is better to live as if there is a hell and find there is not than vice versa.

Our legislature has not enacted civil defense measures as have some other states but it should do so, distributing specific responsibility for the protection of our population. In such legislation the medical profession will be assigned safety measures, and the care and treatment of the injured and ill. Our efforts will be effective in proportion as we have planned and instructed ourselves in the necessary methods. These methods are new and mostly untried. There are those, however, who have perfected new and effective measures for civilian defense in modern and future warfare. We as in-

dividuals must learn something of them if we are to best serve our people.

The small community will probably be spared but should our industrial centers be attacked its means of transportation, communication and hospitalization will be at once paralyzed and the small communities within a radius of 100 miles must furnish the means of help. Therefore, every community must be prepared. Means of rapidly expanding hospital facilities and making available adequate supplies and blood for treatment of the injured must be perfected. Ambulance service and safety teams must be everywhere available.

As a profession we will not wait for legislation to be passed. Each county society and each district will organize committees through which this newer knowledge may be conveyed to individual physicians and nurses. A standby organization of our members must be effected and its personnel replaced or supplemented as required. We do not sidestep our responsibilities and we will not "pass by on the other side" this time.

*Sam A. Overstreet*

PRESIDENT

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# County Society Reports

## FULTON-HICKMAN

A joint meeting of the Fulton-Hickman County Medical Society and the First Councilor District was held at Smith's Cafe, Fulton, on January 17, 1951.

During the dinner music was furnished by Mr. John Austin at the electric organ, and Miss Montell Adams gave a musical program.

Following the dinner, Dr. Russell Rudd, Fulton, president, presided at the meeting.

Dr. J. G. Samuels, Hickman, gave the address of welcome.

Dr. J. Vernon Pace discussed plans of the First Councilor district and topics of national interest to the profession.

The principal speaker for the evening, Dr. Alex J. Steigman, Louisville, was introduced by Dr. J. E. Dunn, Paducah, and spoke on the subject of "The Early Diagnosis of Poliomyelitis."

Out of town guests attending the meeting were as follows: Dr. Alex J. Steigman, Louisville; Dr. and Mrs. J. E. Dunn, Paducah; Dr. and Mrs. J. Vernon Pace, Paducah; Dr. and Mrs. Robert A. Orr, Mayfield; Dr. and Mrs. Conrad H. Jones, Murray; Dr. and Mrs. James C. Hart, Murray; Dr. and Mrs. W. H. Fuller, Mayfield; Dr. and Mrs. Donald C. Haugh, Mayfield; Dr. and Mrs. A. R. Morgan, Mayfield; Dr. and Mrs. Jesse M. Hunt, Kevil; Dr. and Mrs. J. F. Harrell, Bardwell; Dr. and Mrs. Harold F. Funke, Bardwell; Dr. David Y. Keith, Paducah.

Members attending were: Dr. and Mrs. Russell Rudd, Dr. and Mrs. J. G. Samuels, Dr. and Mrs. Ward Bushart, Dr. and Mrs. J. C. Morrison, Dr. and Mrs. D. L. Jones, Dr. and Mrs. J. C. Hancock, Dr. and Mrs. William H. Sewell, Dr. V. A. Jackson, Clinton; Dr. Glenn Bushart, and Dr. and Mrs. J. A. Poe.

J. A. Poe, Secretary

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## JEFFERSON

The 946th meeting of the Jefferson County Medical Society was held on Monday evening January 15, 1951 at the Seelbach Hotel. 134 members were present for the dinner and 20 additional for the business session.

The meeting was called to order at 7:50 p. m. by the President, Dr. J. Andrew Bowen.

Ballots for election of 1951 officers were distributed by the tellers.

The minutes of the previous meeting were read and approved.

The president stated that annual reports of standing and special committees for the year 1950 had been submitted to the Executive Committee which had considered all the reports except four which they wish read by the Committee Chairman.

Dr. David Cox read the reports of the Public Relations Committee, the Diabetes Committee and the Retirement Pension Plan Committee. Dr. Robertson O. Joplin read the report of the Building Committee.

A motion by Dr. Misch Casper, that the annual reports considered by the Executive Committee, as well as those read, be accepted and filed, was seconded and carried.

The following new members were elected: Drs. Thomas P. Walsh, William F. Hawn, Melvin Shein, Dewey H. Reps, Jack Dick, James M. Riley, Jr., John C. Weeter, Alex J. Steigman, all to active membership, and Dr. Joseph T. Gohmann, to associate membership.

The Secretary read a communication from Mr. William H. Harrison regarding office space for rent at 707 Cecil Avenue.

The Secretary read an invitation from the Veterans Administration Hospital and the University of Louisville School of Medicine, to members of the Society to attend a dinner January 25, at which time the guest speaker was to be Dr. W. B. Davis, Baltimore.

The President announced that several meetings of the Committee on Civil Defense, of which Dr. P. M. Crawford is chairman, have been held, and that a teaching program had been planned, the first meeting to be January 24th and 25th, at the Brown Hotel. It was hoped that fifty or more doctors would attend this series of lectures and then make themselves available to go out in the state on call and reproduce the program to other doctors. Members were urged to attend.

Nominations from the floor were opened. Dr. Glenn W. Bryant nominated Dr. George W. Pedigo, Jr., for Treasurer. Seconded by Dr. David Cox and carried. Dr. G. L. Dyer was nominated for Judicial Council. Seconded and carried. There being no further nominations from the floor, nominations were closed.

Ballots were collected by the tellers, and while they were being counted, the President made his retirement address, and introduced Dr. Lytle Atherton, the President for 1951. Dr. Atherton, in a brief talk, made some suggestions to the program committee.

Results of the election of officers was announced by Dr. Lytle Atherton as follows:

Drs. Richard R. Slucher, President-elect; Harry S. Andrews, First Vice President; Lawrence T. Minish, Jr., Second Vice-President; Austin Bloch, Secretary; George W. Pedigo, Jr., Treasurer; David M. Cox, and K. Armand Fischer, Judicial Council. Delegates to Kentucky State Medical Association: Drs. Byron Bizot, Carlos A. Fish, Laman A. Gray, Robertson O. Joplin, Selby V. Love, Paul Mapother, Robert F. Monroe, Carlisle Morse, George W. Pedigo, Harper E. Richey, Henry G. Saam, James E. Winter. Alternate Delegates: Drs. C. Melvin Bernhard, R. N. Holbrook, Hunt B. Jones, James E. Ryan, Horace H. Seay, Tom Jerry Smith.

There being no further business the meeting adjourned at 9:05 p.m.

Austin Bloch, Secretary

### LETCHER

The Letcher County Medical-Dental Society held its monthly meeting in the Whitesburg City Hall, Wednesday night (usual night is Tuesday), January 31, 1951. The following members were present: Drs. Lundy Adams, Blackey, President; Lee Moore, Whitesburg, Vice-President; G. L. Morin, Jenkins; Carl Pigman, Owen Pigman, B. C. Bach, R. Dow Collins.

The meeting came to order with Dr. Lundy Adams presiding; the minutes of the December 1950 meeting were read and approved. After the Secretary read many letters relative to the Blue Coss Hospital and Blue Shield Surgical plans, and with a long discussion of these, the Society unanimously agreed to decline to take advantage of participation in the above plans at the present time. It was clearly shown that as Letcher County is primarily a coal industrial area, and that almost 100% of said people employed in mining, are already under some type of Miner's Insurance, Compensation, or other Welfare benefits, that we could not see how the above Hospital or Surgical plans, could aid either the populace or the practicing physicians, since most doctors are not connected with a hospital, and since it seems clear that only physicians who are connected with some hospital can come under the plans as set out in brochure. To the Society this seemed to be the stumbling block, that is that all patients under said plans must be in a Hospital, and as has been stated this is not usually the case in Letcher County, but are seen either in homes, or in the physicians' offices.

A letter and questionnaire was read on Civilian Defense, and is to be sent in as per request.

Furthermore, the letter pertaining to the Annual County Officers meeting was read; our

President, Dr. Lundy Adams, plans to do his best to attend, Thursday, March 1st in Louisville. We also hope others may attend.

Dr. Billy M. Adams who was on the program for a paper on "Asthma" was unavoidably detained due to "Uncle Sam" who had invited him in to Louisville, to see about Military induction; we regret his absence.

Our Vice-President, Dr. Lee Moore, pleasantly surprised the membership by serving refreshments. Thanks Dr. Lee.

The meeting adjourned at 10:00 p.m. with the next meeting to be on Tuesday night, February 27.

R. Dow Collins, Secretary

### McCRACKEN

The January meeting of the McCracken County Medical Society was held at the Ritz Hotel with Dr. W. P. Hall presiding. There were twenty-six members and six guests present.

The minutes were read and approved after one correction. The following committees were appointed: Library Committee, Drs. Vernon Pace, James Ward, W. Eugene Sloan. Program Committee: Drs. Charles Billington, R. W. Robertson, Coles W. Raymond. Dr. R. L. Reeves reported on progress of Public Relations Committee. Dr. Vernon Pace moved that Public Relations Committee continue their good work. Dr. E. W. Jackson amended motion that funds not be limited to previously designated amount. Motion and amendment seconded by Dr. Eugene L. Blake, passed unanimously.

Admiral Paroe presented medical needs to aid in the civilian defense program. Cooperation was assured, and an answer as to whether there is a need to blood type all residents of this area is to be sent to him after the committee makes a study of it.

Dr. Vernon Pace made a motion, seconded by Dr. James Ward for payment of the following items: Reimburse Dr. George H. Widener, Jr., \$1.50 speaker's supper, \$18.00 cards, \$3.00 stamps, \$2.50 Paducah Press. Passed unanimously.

Dr. Margaret B. Magruder's application was read and referred to the Board of Censors. Motion was made by Dr. Eugene Blake, seconded by Dr. Orion Higdon, and passed to let members decide whether to be made members first of year, or pay dues for 1951 pro-rata from time of acceptance to the County Society.

Motion was made by Dr. R. W. Robertson, seconded by Dr. C. J. Purdy, and passed to



rescind motion of no members asking questions after papers.

Motion was made by Dr. E. W. Jackson, seconded by Dr. R. W. Robertson and passed that the \$2.00 chicken dinner be tried next time.

Meeting was adjourned at 9:00 p.m.

George H. Widener, Jr., Secretary

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### MUHLENBERG

The Muhlenberg County Medical Society met December 15, 1950 with the following members present: Drs. G. F. Brockman, R. E. Davis, J. H. Harralson, George Richardson, G. H. Rodman, G. L. Simpson, J. P. Walton, Claude Wilson, H. H. Woodson. The meeting was called to order by the President, H. H. Woodson and minutes of the preceding meeting were read and approved.

A very considerable volume of routine business was transacted.

A special committee discussed the proposed campaign for the stimulation of Blue Cross and Blue Shield enrollment with the county. Close liaison has been established with Blue Cross representative and an active campaign is being planned for early 1951.

Dr. H. H. Woodson presented a paper on "Uterine Rupture."

The election of officers for 1951 was as follows: Drs. George Richardson, President; F. M. Wilson, Vice-President; G. F. Brockman, Secretary; G. H. Rodman, Delegate of the State Medical Association. It was voted that the delegate term be for two years, and that the alternate delegate be elected at the expiration of two year term of the incumbent delegate. Alternate Delegate, Dr. F. M. Wilson and Dr. Claude Wilson is Censor.

G. F. Brockman, Secretary

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### MUHLENBERG

The Muhlenberg County Medical Society met January 5, 1951. The meeting was called to order by the President, Dr. George Richardson, and minutes of the preceding meeting were read and approved. A considerable volume of routine work was accomplished.

Dr. George Rodman led a discussion on defense against atomic attack. Following considerable discussion, it was agreed that Dr. A. W. Andreassen be elected Atomic Defense Administrator for the Medical profession and that he undertake to prepare for the society the minimum of three programs during the ensuing year on atomic attack. It was envisaged that these lectures would begin with nuclear physics and proceed to the develop-

ment of pertinent methods of treatment.

G. F. Brockman, Secretary

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### SCOTT

The Scott County Medical Society held its regular monthly meeting February 14, 1951 at the John Graves Ford Memorial Hospital. The following members were present: Drs. W. S. Allphin, L. F. Heath, A. F. Smith, D. E. Clark, H. G. Wells, F. W. Wilt, E. C. Barlow, H. V. Johnson.

Dr. D. E. Clark read a case report on "Histoplasmosis in Children" with reports of five cases he had seen in the past few years who had proved positive, evidently benign cases.

Dr. F. W. Wilt stressed the importance of having the general public blood typed and it was moved and seconded that the Society endorse this idea as a defense measure and we urge the public through the press to have this done. Carried.

The Secretary was instructed to write Dr. Cathryn R. Handelman, Maternal and Child Health Division, Kentucky State Board of Health and Mrs. Helen Curry of the Nursing Division to be our guests at the next meeting.

There being no further business the meeting adjourned.

H. V. Johnson, Secretary

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### SHELBY-OLDHAM

Dr. W. H. Nash entertained the Shelby-Oldham Medical Society with a dinner at the Stone Inn, on February 22, 1951.

The following members and guests were present, Drs. W. H. Nash, A. C. Weakley, L. B. Sternberg, H. B. Mack, S. B. May, C. W. Hayes, L. A. Wahle, H. T. Alexander, George Perrine, M. H. Skaggs, B. F. Shields, H. H. Richeson, C. C. Risk and Mr. J. W. Milligan.

The ladies auxiliary met at the same time and after the dinner they retired to another room for their meeting.

President W. H. Nash called the meeting to order and introduced Dr. Frank P. Strickler, Louisville, who gave a very interesting talk on fractures of the head of the femur and the lower third of the tibia. The talk was well discussed by many present.

The secretary called attention to the First Annual County Society Officers' Conference of the Kentucky State Medical Association which will be held at the Brown Hotel March 1st.

The meeting adjourned at 10:00 p.m. The next meeting will be on March 22nd when Dr. C. Wyatt Norvell will be the host.

C. C. Risk, Secretary

## News Items



**JAMES M. MOLLOY**

Mr. James M. Molloy, Lexington, was elected president of the Kentucky Child Health Foundation February 16, 1951. He succeeds Dr. James Bruce, Louisville. Other officers named at the annual meeting were: Vice-President, Sidney Rosenblum; Second Vice-Presidents, Mrs. Irvin Abell, Jr.; Dr. Fred W. Rankin, Lexington; Rogers C. B. Morton, and Mrs. Inez Ligon, and Secretary, Miss Mary Gans.

Dr. Alex J. Steigman, professor of child health at the University of Louisville Medical School, a post sponsored by the foundation, reported on the year's work for child health. His recommendations included seminars for general practitioners who handle eighty-two per cent of the cases of children's diseases.

Dr. James M. Riley, Jr., announces the occupancy of his offices for the practice of Orthopaedic Surgery in the Fincastle Building, Louisville. Dr. Riley was graduated from the University of Louisville School of Medicine in 1944 and served his internship at Louisville General Hospital and Kosair Crippled Children's Hospital. He served in the Army during World War II.

Drs. I. Z. Barber, K. L. Barnes and Ralph L. Cash have been appointed members of the Caldwell County Board of Health. The appointments are for a two year period, ending January 1, 1953.

Dr. C. E. Crabtree has opened an office in Buffalo, Larue County, for the practice of medicine. Dr. Crabtree is a graduate of the University of Tennessee Medical School in Memphis and has just completed his year's internship at Knoxville General Hospital in Knoxville, Tennessee.

Dr. William E. Hoy, Jr., has opened an office for the practice of Internal Medicine including Allergy in Ashland. Dr. Hoy received his B. S. Degree from the University of South Carolina in 1940 and was graduated from the Medical College of Virginia in 1943. He served an internship at the Cleveland Clinic, Cleveland, following which he served two years in the Army. After his discharge he completed a three year Fellowship in Internal Medicine at the Cleveland Clinic. From January 1949 until June 1950 he had a residency in Pathology at Saint Luke's Hospital, Cleveland, Ohio. Dr. Hoy is formerly from Columbia, South Carolina.

Dr. H. C. Jasper, retired Richmond surgeon, was recently awarded a diamond service button by the L. & N. Railroad. The presentation was made by Dr. J. A. Stoeckinger, district surgeon, Lexington. Dr. Jasper was a native of Jessamine County and after graduating from the old Medical School of the University of Louisville in 1889 he did post graduate work in both Philadelphia and New York. Returning to his home state he first practiced in Junction City, Boyle County, and then at Kirksville, Madison County. Dr. Jasper moved to Richmond in 1896 and was appointed local surgeon for the L. & N. in 1900. He retired from active practice two years ago.

Dr. Fred C. Reynolds was informed by Dr. F. H. Arestad, associate secretary to the Council on Medical Education and Hospitals, American Medical Association, that the Reynolds Clinic-Hospital had been admitted to the hospital register of the American Medical Association.

Dr. G. H. Freeman who has practiced medicine at Plano for fifty years was honored by the Warren-Butler-Edmonson Medical Society at their monthly dinner meeting at the Helm Hotel, Bowling Green on February 13, 1951. Dr. Freeman was presented a gift on behalf of the society by the late Dr. John H. Blackburn.



## *In Memoriam*



**JAMES H. PRITCHETT, M. D.**

**Louisville**

Dr. James H. Pritchett, pediatrician and professor of pediatrics at the University of Louisville School of Medicine for many years, died February 1, 1951 of a heart attack. He had practiced in Louisville since 1911. Dr. Pritchett was a native of Independence, Missouri, and was graduated from the University of Louisville Medical Department in 1911. He continued his study of pediatrics at Bordeaux, France.

Dr. Pritchett was a staff member of eight hospitals in Louisville and was president of the Kentucky State Medical Association in 1944. He was a member of many civic and medical groups and was consultant at Children's Hospital and several other institutions for children. He was a Major in the Medical Corps during World War I.

**SAMUEL RAY BAKER, M. D.**

**Lexington**

Dr. Samuel Ray Baker, Lexington, died January 18, 1951 of a bullet wound in the chest. Dr. Baker was chief of professional services at the Veterans Administration Hospital. He apparently had been cleaning his guns prior to leaving on a vacation when the

rifle accidentally discharged, wounding him fatally.

Dr. Baker had been with the Veterans Administration since 1931. Before joining the Veterans Administration he served at Chillicothe, Ohio; Northport, New York, and Little Rock, Arkansas. He served in the Army as a lieutenant colonel from 1944 to 1946 and was a member of the inactive reserve. Dr. Baker was a graduate of the University of Arkansas School of Medicine in 1929.

He was a member of the Fayette County Medical Society and the Blue Grass Psychiatric Society.

**GEORGE EZRA TITSWORTH, M. D.**

**Bandana**

Dr. George Ezra Titsworth, Bandana physician, died January 10, 1951 at the home of his son, Dr. H. E. Titsworth, Clinton, following a pulmonary infarct. Dr. Titsworth had been a general practitioner at Bandana since August 1910 when he was graduated from the University of Louisville Medical Department. He had been the only doctor in Bandana for twenty years and in his forty years of practice had delivered about 1900 children.



**CARROLL C. ENGLISH, M. D.**

**Louisville**

Dr. Carroll C. English, retired Louisville physician, died February 19, 1951. He practiced medicine for forty-three years until his retirement in 1947. From 1904 he maintained a general practice. After taking postgraduate work in 1920 he devoted most of his practice to gynecology and obstetrics.

Dr. English was born at Cecilia, March 4, 1878. He attended Georgetown College and

was graduated from the University of Louisville Medical Department in 1903. He interned at the Louisville General Hospital and began his practice in March 1904.

During World War I he served as captain in the Medical Corps and was assigned a surgeon in the Corps of Engineers. After the war he took postgraduate work at Women's Hospital and the Lying-In Hospital in New York.

Until his retirement Dr. English was on the active staffs of Kentucky Baptist Hospital, Jewish Hospital, and was on the courtesy staffs of St. Joseph Infirmary and Norton Memorial Infirmary.



HARRY M. WEETER, M. D.

#### Louisville

Dr. Harry M. Weeter, Louisville, died February 25, 1951 of a heart ailment. Dr. Weeter had operated a clinical laboratory in Louisville since 1928 and was a former professor at the University of Louisville School of Medicine. Dr. Weeter was born in Sligo, Pennsylvania, December 7, 1887. He received his B. A. degree in 1911 at Allegheny College, Meadville, Pennsylvania. In 1917 he received his M. S. degree at the University of Illinois, and in 1922 he received a Ph.D. degree at the University of Chicago, where he was instructor in bacteriology from 1918 to 1922. While there he won the Howard Ricketts Prize for research in bacteriology. He came to Louisville in 1922 as professor of Bacteriology and Pathology at the University of Louisville School of Medicine where he took the degree of doctor of medicine in 1927. A year later he opened a clinical laboratory in the Heyburn Building.

Dr. Weeter was former pathologist at St. Joseph Infirmary, Jewish Hospital, and Saints Mary and Elizabeth Hospital in Louisville; St. Edward's Hospital, New Albany, and Clark County Memorial Hospital, Jeffersonville.

He was former president of the Jefferson County Medical Society, and Kentucky Society of Pathologists. He was a diplomate of the American Board of Pathology.

## BOOK REVIEWS

**AN ATLAS OF HUMAN ANATOMY**, by Harry J. Anson, Ph.D., Professor of Anatomy, Northwestern University Medical School. 518 pages, with 1301 illustrations, 93 in color. W. B. Saunders Company, Philadelphia, publishers. Price \$11.50.

This Atlas will be of great assistance to students in medicine and general practitioners and surgeons as it is one of the most complete works on human anatomy available, and is used by thirty per cent of the medical schools in this country. The three-dimensional illustrations were drawn at the dissection table and prepared by skilled artists. Another interesting feature is its presentation of variations from normal anatomy, and arranged in regional sections. The detailed legends, together with the parts plainly lettered on the illustrations, constitute the equivalent of a laboratory manual. It is concise, easily handled and a volume whose wealth of illustrations and clear details make it a ready reference desk volume.

**RESEARCHES IN BINOCULAR VISION** by Kenneth N. Ogle, Ph.D. Section on Biophysics and Biophysical Research; Research Consultant in the Section on Ophthalmology, Mayo Foundation and Mayo Clinic, Rochester, Minnesota. Illustrated. Publishers: W. B. Saunders Company, Philadelphia. 1950.

The author has presented only nonclinical aspects of the researches in binocular vision, though frequently data obtained in the clinic are used for supporting evidence. The greater part of the subject matter in this book is based upon the researches in binocular vision conducted at the Dartmouth Eye Institute at Hanover, New Hampshire. The plan of the book is to describe in order those researches which have dealt, first, with the specific sensorial organization of the two retinas; second, with those functional processes known as fusion, third, with the functional effect of altering the relative magnification of the images of the two eyes, especially upon the space sense; and



last, with the anomalous condition of aniseikonia as a factor in efficient binocular vision and its bearing upon our concepts of the stability of the organization between the two retinas.

The book is well illustrated with charts and tables and while excellent for the Ophthalmologist the general practitioner can get an adequate knowledge of the subject.

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**FREUD: Dictionary of Psychoanalysis**, Edited by Nandor Fodor, Associate for the Association for the Advancement of Psychotherapy and Frank Gaynor, Co-Author of the "Dictionary of Industrial Psychology" with a preface by Theodore Reik, Author of "Listening With the Third Ear." Philosophical Library, Publishers, New York. Price \$3.75.

This volume is a complete glossary of all the basic terms in psychoanalysis as defined and explained in the words of Dr. Sigmund Freud, founder of the school of psychoanalysis. The concise definitions, each taken word for word from the epochal writings of Dr. Freud, cover all the basic terms and concepts in this new science of the human mind. To prepare this work, all of Dr. Freud's writings, books, papers, letters, communications—were carefully studied, words and concepts extracted, and the most informative definitions, as Freud himself formulated them, incorporated in this glossary.

A genuine storehouse of information for the layman, this volume is at the same time an extremely convenient and useful reference work for the psychologist, psychiatrist, and psychoanalyst.

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**THE ANTIHISTAMINES, THEIR CLINICAL APPLICATION**, by Samuel M. Feinberg, M. D., Associate Professor of Medicine, Chief of Division of Allergy and Director of Allergy Research Laboratory; Saul Malkiel, Ph.D., M. D., Assistant Professor of Medicine, Director of Research Allergy, Research Laboratory, and Allan Feinberg, M. D., Clinical Assistant in Medicine, Attending Physician in Allergy Clinic, Northwestern University Medical School. 291 pages. The Year Book Publishers, Inc., Chicago, Publisher. Price \$4.00.

Since this new drug has made its appearance on the medical stage, it is very essential that every physician and surgeon be acquainted with its clinical application, its origin and its effect on the human body. The purpose of the book is to condense the facts and the practical application of the antihistamines. It is divided into two sections, clinical and experi-

mental. This book is primarily clinical, intended for every physician in any field of medicine in which the use of antihistamines is considered. It is based on several thousand therapeutic case-trials. There are several chapters devoted to the experimental work in this field. It is a digest of all available knowledge of the origin and administration of this interesting drug.

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**THE PHYSICIAN EXAMINES THE BIBLE** by C. Raimer Smith, B. S., M. D., D. N. B. Philosophical Library, New York. Price \$4.25. 1950.

The author is a physician in general practice, and was for several years a specialist in pathology and clinical laboratory science. His hobby was the study of the Bible and he has examined the Old and New Testaments and Apocrypha for the etiology, diagnosis and prognosis of diseases at that time and compares them with the present day practices.

Many of the diseases of the present time the Bible spoke of, for instance, Tuberculosis or Consumption, "I also will do this unto you; I will even appoint over you terror, consumption, and the burning ague, that shall consume the eyes, and cause sorrow of heart." Lev. 26:16, are the same as today.

This book is well worth while for any doctor to have in his library.

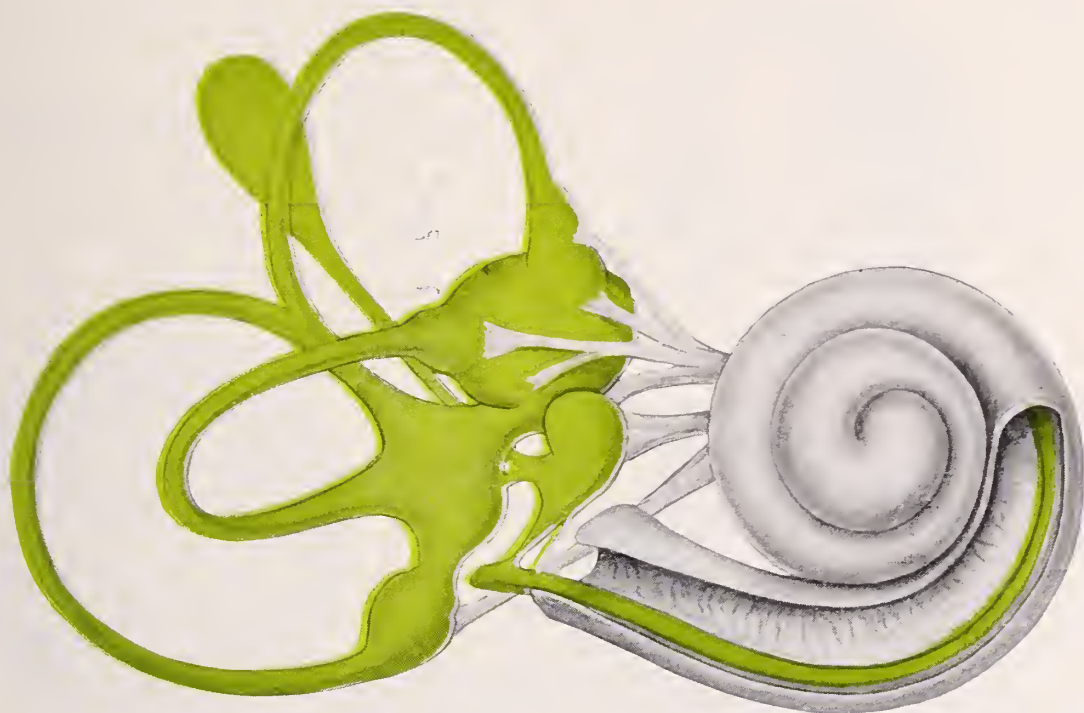
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**MEDICAL DIAGNOSIS, Applied Physical Diagnosis**. Edited by Roscoe L. Pullen, M. D., F. A. C. P., Professor of Graduate Medicine, Director of the Division of Graduate Medicine, and Vice Dean of the School of Medicine, Tulane University of Louisiana at New Orleans; Consultant of Medicine, Veterans Administration Hospital, New Orleans, Louisiana; Consultant to the Surgeon General, Department of the Army, Washington, D. C. Second Edition. With 601 figures, 49 in colors. W. E. Saunders Company, Publishers, Philadelphia. 1950. Price \$12.50.

Although there has been great advances made in therapy and laboratory facilities it is very difficult at times for the doctor to find out what is exactly wrong with the patient. With this in view the author has designed the New Second Edition to be a valuable aid to the general practitioner.

The author and his 23 eminent co-authors explain all the fine points of history taking, inspection, percussion, palpation, auscultation, endoscopy, X-ray, electro-cardiography etc.

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—Tuttle, A. D.: *Special Breakdown of Case Histories*, presented at the Airlines Medical Directors Association Meeting, New York, N. Y., Aug. 28, 1949.

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fact that there is still no substitute for the considered evaluation of the whole patient by the physician and that the test tube does not make a diagnosis. Expert guidance is given on what to look for and how to evaluate findings. In the book the physician is told how to weigh his observations and test results against his own experience and judgment, how to set up a differential diagnostic pattern that will pinpoint his patient's disorder and with a minimum of time and effort. The author impresses the reader with the necessity of thoroughness, because more faulty diagnoses are from errors of omission than from errors of commission.

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**A TEXT-BOOK OF X-RAY DIAGNOSIS.** Second Edition, by British Authors, in four volumes. Edited by S. Cochrane Shanks, M. D., F. R. C. P., F. F. R., Director, X-Ray Diagnostic Department, University College Hospital, London, and Peter Kerley, M. D., F. R. C. P., F. F. R., Director, X-Ray Department, Westminster Hospital, Radiologist, Royal Chest Hospital, London. Volume III., 830 pages with 694 illustrations. W. B. Saunders Company, Publishers. Price \$18.00.

Diagnostic radiology is becoming an increasingly complex specialty, and it is difficult for one person to be equally expert in all its branches. The editors were fortunate in having the help of collaborators, both radiological and clinical, who are distinguished in particular branches of the subject, which makes this work more authoritative in that it is of more value, not only to the postgraduate student of radiology, but also the clinician. Part One deals with the Alimentary Tract; Part Two, the Biliary Tract; Part Three, The Abdomen; Part Four, Radiology in Obstetrics; Part Five, Gynecological Radiology and Part Six, the Urinary Tract.

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**POLIO AND ITS PROBLEMS,** by Roland H. Berg, with a foreword by Basil O'Connor, President, The National Foundation for Infantile Paralysis, Inc. 24 Illustrations. 174 pages. Published by J. B. Lippincott Company, Philadelphia.

As poliomyelitis is now striking infants less and less but teen age youths and adults more and more, this book will be interesting to the profession because it contains a cavalcade of tireless research, perilous experiment and stern persistence as science answers the challenge of this disease in its indiscriminate attack on various age groups. The author creates the steps that have been taken since the first probings into the cause, cure and pre-

vention of infantile paralysis; he bares the specter of defects which have incited more relentless scientific effort, and describes clearly the tremendous problems and obstacles yet to be overcome.

This book is a tribute to those intimately engaged in the fight against the disease. It is also a laurel to the American people who have so generously sponsored a continuous coordinated research program with funds.

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**THE CONQUEST OF BACTERIA** From Salvarsan to Sulphapyridine by F. Sherwood Taylor; foreword by Henry E. Sigerist. Publishers: Philosophical Library, New York. Price \$2.50.

This book written by one of England's most eminent scientists and "simplifiers" of scientific knowledge, is the story of the chemical discoveries which conquered disease and of the men behind these conquests. For a truly brilliant account of the Knights of Medicine in their immortal struggle with the terrors of human disease this book is interesting and absorbing. This is one of the best types of popular books on a scientific subject and it should be most welcome to the physicians, as well as the laity who have read accounts of the new miracle drugs in the newspaper and Medical Journal, and would like to know what it is all about.

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**NATURAL CHILDBIRTH, A Manual For Expectant Parents** by Frederick W. Goodrich, Jr., M. D. 176 pages. Illustrated. Publishers: Prentice-Hall, Inc., New York. Price \$2.95.

This is an authoritative handbook containing complete information on diet, exercise and the physiology of pregnancy and birth covering aspects of "childbirth without fear" and including photographs from the Maternity Center Association Birth Atlas. Questions of immediate post-natal care, or rooming-in and breast feedings are discussed. In each instance, the specific and detailed instructions are accompanied by the most up-to-date diagrams and illustrations.

The purpose of this book is to prepare the expectant mother both physically and mentally for satisfying emotional experience rather than a painful ordeal. Reading this book is like having a friendly and understanding visit with him.

The emphasis throughout is on the naturalness of the birth process, the need of knowledge to dispel fear and the complete cooperation which can exist between a woman and her doctor.

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**CURRENT THERAPY, 1951. Latest Approved Methods of Treatment For The Practicing Physician.** Editor, Howard F. Conn, M. D. Consulting Editors, M. Edward Davis, Vincent J. Derbes; Garfield G. Duncan; Hugh J. Jewett; William J. Kerr; Perrin H. Long; H. Houston Merritt; Paul A. O'Leary; Walter L. Palmer; Hobart A. Reimann; Cyrus C. Sturgis and Robert H. Williams. Publishers: W. B. Saunders Company, Philadelphia. Price \$10.00.

Contributors to Current Therapy 1951 have been carefully selected not only for their active interest in the specific disease discussed but also as recognized authorities in the medical world. They have set down their present methods of treating the disease in brief, to-the-point discussions devoid of extraneous material but in the exact detail necessary for proper management of the illness. The articles are original and have been written expressly for this volume. All material has been reviewed by the authors just before publication to assure the inclusion of the latest standard therapy.

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**DISEASES OF THE TROPICS** by George Cheever Shattuck, M. D., Professor of Tropical Medicine, Harvard Medical School and Harvard School of Public Health, Emeritus; Consultant of Tropical Diseases, Boston City

Hospital, and Massachusetts General Hospital. Publishers: Appleton-Century-Crofts, Inc., New York.

Modern war and travel have increased the contact between the temperate and tropical regions to such an extent that a knowledge of the diseases of the tropics is no longer the province only of the specialist in that field. A working knowledge of the prevalent tropical diseases has become necessary to the medical student and to the general practitioner.

The primary objective in the preparation of this book has been to offer at moderate cost a concise but comprehensive account of the diseases of the tropics. The maladies of major importance have been described in considerable detail whereas those of lesser importance have been dealt with more or less briefly. Malaria, yaws, leishmaniasis, the typhus fevers, yellow fever, plague and cholera have been stressed.

The book should be of service to those who are concerned with public health programs because epidemiology, prevention and control are outlined for each disease.

The illustrations were selected carefully for graphic qualities and the tabulated data present significant material in compact form. The systematic arrangement of the text and the comprehensive index are planned for ease of reference.

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**THE DIABETES GUIDE BOOK For Physicians.** Published by the American Diabetes Association, 11 West 42nd Street, New York 18, New York.

This little volume contains a simple but complete survey of the current information about this disease, its diagnosis and treatment, written for every day use by the general practitioner. Prepared by the Committee on Education of the American Diabetes Association, the Guide Book concisely presents the basic principles which every physician should know about diabetes.

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## THE DIAGNOSIS OF SURGICAL JAUNDICE

Melvin L. Dean, M. D.

LEXINGTON

Jaundice is the condition recognized clinically by yellowish discoloration of the skin and mucous membrane due to staining by the bile pigment bilirubin when this pigment is present in excess amount in the blood stream. Bilirubin must reach a certain concentration in the blood before one is able to recognize clinical jaundice, and even then it is easily overlooked in artificial light, consequently, unless serum bilirubin determinations are made at repeated intervals transient fluctuations which may have diagnostic value can be overlooked. In a case of fairly long standing jaundice, clinical estimation of its intensity is frequently misleading, as once the tissues have become deeply stained with the pigment they retain it for some time even after the serum bilirubin has diminished.

### Physiology

Jaundice usually occurs when the bile pigment concentration of the blood exceeds 2 mgm. per cent<sup>9</sup>. Bile pigment is derived from the hemoglobin of destroyed red blood cells and is formed chiefly by the reticulo-endothelial cells of the spleen and bone-marrow. The Kupffer cells of the liver also form a small amount of bilirubin but the great source is outside the liver. This extra-hepatic bilirubin is extracted from the blood by the liver cells and is discharged into the bile. In this process the liver cells alter the pigment chemically as it passes through them. The bilirubin is transformed from a colloid to a crystalloid state by the removal from it

of a protein molecule<sup>7</sup>. This altered bilirubin found in the bile is able to pass through the kidney and when present in the blood in an excess amount shows up in the urine. This is a post-hepatic bilirubin. In jaundice due to an excess of pre-hepatic or colloid state bilirubin it is not filtered through the kidney and does not appear in the urine, the so-called acholuric jaundice. These two forms of bilirubin are the basis for the Van den Berg reaction.

In jaundice with bilirubin in the urine an immediate direct reaction is obtained. If there is no bilirubin in the urine then the pigment must be in its colloid state and the Van den Berg reaction is indirect or delayed, because the protein part of the molecule has to be extracted before the color reaction is obtained.

### Types

Jaundice may be either of three types: 1. Pre-hepatic jaundice: The etiology being outside the liver. It is due to increased destruction of red cells so there is an excessive amount of bilirubin formed. Congenital hemolytic jaundice is of this type. 2. Intra-hepatic jaundice: This is hepatocellular jaundice and is due to some disturbance within the liver itself. Toxic and infectious types fall in this group. The liver cells are unable to excrete the normal components of bile, and this leads to an accumulation of bilirubin in the serum. This type rarely occurs in a pure form and the Van den Berg reaction may be either indirect or direct but it is usually the latter. Infectious hepatitis is an example of hepatocellular jaun-

Read before the Scott County Medical Society, Georgetown, June 22, 1950.



dice. 3. Post-hepatic jaundice: This is due to some impediment to the flow of bile into the duodenum and is therefore obstructive. As a result there is regurgitation of bile into the blood. The bilirubin in these cases has passed through the liver cells and is in a crystalized state, and therefore is able to pass over into the urine, and a direct Van den Berg reaction is obtained on the blood. The obstruction may be complete, incomplete, or intermittent and thus the laboratory findings may vary. Common duct stones, strictures of the ducts, or carcinoma of the ampulla or head of the pancreas may be responsible for the obstruction.

### Diagnosis

When the physician sees a case of jaundice his first problem is to determine whether or not it is hemolytic, hepatocellular, or obstructive in origin. A good history and physical examination mean more than anything else in making the diagnosis, but often laboratory aids are necessary. Many tests of liver function have been devised based on the numerous functions of the liver. There is no test that will test several functions of the liver at one time. It was originally assumed that these tests would show an impairment of liver function in hepatocellular jaundice and very little if any impairment in obstructive or surgical jaundice. It was soon realized that this concept carried many pitfalls, because some element of obstruction is present in hepatocellular jaundice due to compression of the biliary radicles in the liver while conversely a certain amount of cellular damage occurs in pure obstructive jaundice due to back pressure of the obstruction to the biliary flow.

If the jaundice is obstructive in origin then we must go one step further and determine whether or not the obstruction is extra-hepatic and amenable to surgery. In extra-hepatic obstruction of the bile passages secondary liver damage appears relatively soon due to a damming back of injurious bile products in the liver. The length of time for this to develop depends on the degree of obstruction present but averages two to four weeks<sup>6</sup>. For this reason liver function tests are more reliable if performed early in the course of the disease.

It is impractical to run all the liver tests in a given case as they tend to duplicate information already obtained. The following list is suggested as a basic

group for adequately distinguishing medical from surgical jaundice.

### Laboratory

- A. Tests for obstruction to bile flow.
  1. Icterus index.
  2. Urobilinogen excretion in urine and stool.
- B. Tests for hepatocellular damage.
  1. Galactose tolerance test—tests the carbohydrate metabolism of the liver.
  2. Cephalin — cholesterol flocculation test.
  3. Thymol Turbidity Test.
  4. Prothrombin time.
  5. Bromsulfalein test.
- C. Liver Biopsy.

### Tests for Obstruction to Bile Flow

**ICTERUS INDEX:** This is a colorimetric test in which the color of the fasting serum is compared with a standard potassium dichromate solution. It is reported in units. Normal 4-6. It may rise to 15 before clinical jaundice is noted.

Main use is to follow the progress of the jaundice.

**UROBILINOGEN EXCRETION:** Urobilinogen is a reduction product of bilirubin which is formed in the gastrointestinal tract by the action of bacteria. Most of it leaves the body via stool. A small amount is re-absorbed by the portal circulation and carried back to liver where it is re-excreted into the bile. If there is damage to liver cells so that this re-excretion cannot take place the urobilinogen is excreted by the kidney, and consequently appears in the urine in increased quantities in hepatocellular jaundice. Normal for stool—150-300 mgm. per 100 gm. of stool in 24 hour specimen. Normal for urine, 4 mgm. or less in 24 hour specimen.

- A. Obstructive jaundice. Stool: Decreased or absent. Urine: Varies directly with amount in stool.
- B. Hepatocellular. Stool: Normal. Urine: Increased due to failure of liver cells to re-excrete.
- B. Hemolytic. Stool: Increased. Urine: Increased due to excessive production of bile pigments.

### Tests for Hepatocellular Damage

**GALACTOSE TOLERANCE TEST:** This is one phase of the carbohydrate metabolism of the liver, galactose being converted to glycogen. The amount not metabolized is excreted in the urine. Normally when 40 gm. is given orally, less than 3 gm. will

be excreted in the urine in a five hour period. In hepatocellular jaundice the utilization of galactose by the liver is impaired, so that more than 3 gm. may be recovered in the urine. In obstructive jaundice, utilization of galactose by the liver is not impaired, so that less than 3 gm. is excreted in the urine. The test can also be done intravenously and is more sensitive.

**CEPHALIN CHOLESTEROL FLOCCULATION TEST:** This test is based on alterations of albumin and globulin fractions of the serum in patients with liver damage. This change causes a flocculation of a prepared cephalin-cholesterol emulsion in the presence of physiological saline solution. It is read after 48 hours and is reported on the basis of one to four plus. It is positive in early hepatocellular damage. It is negative in obstructive jaundice unless of sufficiently long duration so that secondary liver damage has occurred. This test is sensitive and fairly reliable as a screening test.

**THYMOL TURBIDITY TEST:** This test is also based on the ability of the liver cells to produce normal serum protein fractions. It is sensitive, easy to perform, and is one of the most reliable tests in the differentiation of hepatocellular from obstructive jaundice.

**PLASMA PROTHROMBIN TIME:** Prothrombin is formed by the liver when adequate amounts of Vitamin K are absorbed from the intestine. The presence of bile in the intestine is necessary for the absorption of this fat-soluble vitamin, consequently, the prothrombin time may be prolonged due either to the exclusion of bile from the intestinal tract or to liver damage and the failure of production of prothrombin. If the prothrombin time is prolonged and Vitamin K is given parenterally, the response obtained is a measure of liver function. If there is little change in the prothrombin time, it indicates severe hepatocellular damage, whereas rapid return to normal means that the jaundice is most likely on an obstructive basis or that the liver is not damaged. This test is not sensitive but may have real prognostic value when surgery is contemplated.

**BROMSULFALEIN TEST:** This is a test of the ability of the liver to excrete certain dyes, and is very reliable in the absence of jaundice. It offers little help in deciding whether or not a jaundiced patient is a surgical problem.

**LIVER BIOPSY:** There has been much interest in liver biopsy in the past decade. By this means much knowledge has been gained concerning infectious hepatitis and early cirrhosis. Biopsies may be obtained at laparotomy, by peritoneoscopy, or by needle. The needle or punch biopsy method is widely used now and is so commonly employed that reports of cases have ceased to appear in the literature as such. The early reports emphasized the dangers of the procedure and the deaths resulting from it. Since then, realization of certain contraindications, and improvement in technic have reduced the chance of hemorrhage. The procedure may be carried out through the right lower chest or through the upper abdomen. Even the early reports of collected cases gave a mortality of less than one-half of one per cent, and by now it is certainly lower.

Schiff and his co-workers at the University of Cincinnati reported on a group of cases numbering between 500-600 and gave the following approximate figures<sup>8</sup>:

In 1/2 the cases the clinical diagnosis was confirmed.

In 1/5 the cases the clinical diagnosis was corrected.

In 3% an unsuspected disease was found.

In 3% the diagnosis was misleading.

In 6% the specimen obtained was inadequate for diagnosis.

In the remainder the biopsy findings were non-contributory to the case.

In carcinomatosis it is considered to be as accurate as laparotomy or even more so because the specimen obtained will be more than a surface biopsy.

The procedure is useful to rule out liver disease, to diagnose granulomatous and uncommon diseases, to diagnose and follow the progress of treatment in cirrhosis and in the differential diagnosis of jaundice.

### Summary

An attempt has been made to point out the necessary procedures for a differential diagnosis of jaundice. The laboratory tests are of great importance but a complete history and physical examination are also essential in determining the etiology of the condition. The surgeon must decide whether or not the case of jaundice is amenable to surgery.



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## HYPERSPLENISM

Edward Rankin, M. D.

LEXINGTON

The spleen serves three well recognized purposes: (1) the final destruction of blood cells; (2) the storage of blood; and (3) the manufacture of lymphocytes in the lymphoid tissue composing the malpighian corpuscles. The normal human spleen is apparently not essential to life or health. Conversely, the pathologic human spleen may threaten both health and longevity. There may exist for the spleen conditions associated with a hyperactivity of some of its functions and to such a condition the term 'hypersplenism' was first applied in 1914 by John H. King of Johns Hopkins. This entity has since been studied by numerous groups of which Doan, Wiseman, Damashek, Bloom, Krumbhaar, and Evans are only a few. The purpose of this paper is to review the literature on this subject and present the present theories of cause and effect in this interesting syndrome.

The once physiologically nonessential spleen has now proved itself to be an exceedingly unstable and therefore pathologically important organ. Whether it has inherited, as a Mendelian dominant gene factor, the primary capacity to withhold and destroy excessive numbers of circulating red blood cells, as in congenital hemolytic icterus, or platelets as in thrombocytopenic purpura, or granulocytes as in splenic neutropenia, or perhaps destroys all three types of cells indiscriminately at the same time as in pan-hemato-  
penia, or whether the spleen acquires these traits secondarily through being involved by a number of unrelated constitutional diseases such as the leukemias, Banti's disease, Hodgkin's disease, or sarcoma, when the hypersplenic mechanism has

been established by the appropriate diagnostic procedures splenectomy is usually mandatory and effective in relieving the condition.

### Anatomical Structure

The structure of the spleen in its relaxed condition in the living body is three to five times larger than post mortem examination reveals as it contracts to minimal proportions in the throes of death. The capsule of the spleen is provided with smooth muscle fibers which penetrate its substance into the depths of the organ. Blood is delivered to the splenic pulp by fine arterial vessels and it percolates between the pulp cells. It is collected again into venous sinuses whose walls are formed by reticuloendothelial cells. The spleen has a semi-open circulation controlled by a filter mesh mechanism in the sinus wall, which under diverse pathologic conditions may be altered, either in the direction of greater or lesser selective permeability to the cellular elements of the blood. This mechanism operates to separate the cells from the plasma and thus to concentrate in the spleen, both within and without the sinuses, in varying degree and quantity, blood cells of various types and quality. The more disturbed the circulatory equilibrium, the more profound and prolonged the stasis, the more does the spleen seem to lack discrimination and withhold normal as well as fragile senile and damaged elements.

As seen histologically the spleen is not unique but contains the same lymphocytes and reticuloendothelial phagocytes as seen in the bone marrow, mesenteric lymph nodes and diffuse connective tissue. The islands of lymphoid tissue in

the spleen, malpighian corpuscles, are merely germinal areas for lymphoid tissue and do not differ in function from lymph nodes.

Contraction and relaxation of the spleen is brought about by the smooth muscle in its capsule and trabeculae. Contractions occur after exercise, hemorrhage, and adrenalin stimulation and knowledge of this fact allows for a nonsurgical splenic biopsy. By securing peripheral blood studies before and after injections of adrenalin a biphasic curve of total cell and differential fluctuations will reflect in 60 to 90 minutes the contraction and subsequent relaxation of spleen and reveal its potential mobilizable splenic cell content. It is possible with sodium pentobarbital to induce relaxation of the spleen and produce a transitory reduction of as many as 37 per cent of the circulating erythrocyte population.

### Primary Hypersplenism

Primary hypersplenism has been defined as an hyper-instability of the spleen, sometimes inherited as a Mendelian Gene factor, as in congenital hemolytic icterus, and at other times as "spontaneous" hypersplenic episodes unrelated to any demonstrable internal or external environmental cause. Such physiologic stresses as normal pregnancy, minor infections, and traumata frequently and repeatedly precipitate more or less severe hypersplenic exacerbations or crises in susceptible patients.

It is seldom that a "pure" hemolytic, or an unadulterated thrombocytopenic or neutropenic syndrome is encountered. The predominant picture may be anemia, with or without jaundice, or purpura, or Ludwig's angina and infection, but any one of these symptom complexes may have a subclinical, if not clinical, cytopenia involving one or more of the other elements of marrow origin. At different stages in the clinical course of the same patient differing degrees of panhematocytopenia may be observed. Those clinical entities recognized under the general category of primary hypersplenism are congenital hemolytic icterus, idiopathic thrombocytopenic purpura, splenic neutropenia, and splenic panhematopenia.

Doan, in one of his early papers on primary splenic neutropenia, postulated that primary splenic neutropenia, congenital hemolytic icterus, and essential thrombocytopenic purpura, were each re-

lated and that the predominating clinical hematologic syndromes blended into and involved to a greater or lesser degree the other. A review by his group of several cases of congenital hemolytic icterus and essential thrombocytopenic purpura, revealed each was often accompanied by more or less definite reduction in other circulating units including leukocytes. This viewpoint is generally held by other workers also.

Primary hypersplenism must be considered in any case which demonstrates either anemia, thrombocytopenia, granulocytopenia, or any combination of these findings in the peripheral blood, when the bone marrow studies reveal a hyperplastic type of picture for the elements involved and there is no evidence of leukemia in the peripheral blood or bone marrow.

Doan, in his classical description of splenic neutropenia, listed the following clinical diagnostic points: splenomegaly, occasional purpura depending on associated thrombocytopenia, occasional oral ulceration depending on the acuteness and severity of neutropenia, and occasional mild icterus depending on the degree of associated anemia. The hematologic study revealed a hyperplastic bone marrow for myeloid series and if hemolytic anemia was present for erythroid series also. No abnormal cells were seen in the bone marrow and leukemia was not present. The peripheral blood revealed marked specific neutropenia, anemia, when present was macrocytic hyperchromic in type, reticulocytosis if anemia was definite, increased Van Den Berg depending on grade of anemia, and a variable thrombocytopenia.

Primary hypersplenism is not to be confused with Banti's syndrome as there was no evidence of portal hypertension or cirrhosis of the liver in any case. It is also separate from Felty's syndrome of arthritis, anemia, splenomegaly, and leukopenia which etiologically is believed the result of chronic infection. This was clearly demonstrated by Price and Schoenfeld.

Splenomegaly and leukopenia occur with a wide variety of infections, however, there is an absence of myeloid hyperplasia, thrombocytopenia, and hemolytic anemia. Leukemia and aleukemic leukemia are the most difficult diagnostic problems but bone marrow studies and blood smears clarify the diagnosis.

In differential diagnosis aspiration of the bone marrow to rule out leukopenic



leukemia, aplastic anemia, pernicious anemia, and neoplasia is essential. Historical facts relating to drugs and the presence of recent contact with certain infectious diseases must be negative. There must be no pathologic cells in either the blood or bone marrow.

### **Hypersplenism Secondary to Other Disease**

During the course of a number of diseases such as Banti's syndrome, Goucher's disease, the leukemias, Hodgkin's disease, to mention only a few, the spleen may become secondarily involved and in certain proportion of these cases there develops a syndrome identical with one or the other of those already described as primary hypersplenism, in which both specific splenic hypersequestration and compensatory bone marrow hyperplasia may be demonstrated though there is no familial history of such a trait. Hemoclastic crises may occur which threaten the survival of the individual quite independently of his basic disease.

Doan reported a series of 270 splenectomies for hypersplenism. 65 per cent were classified as without other demonstrable disease, or primary, and 35 per cent as secondary to some other obvious basic pathology.

### **Acute Hemoclastic Crises**

The hypersplenic mechanism, whether primary or secondary, may precipitate some of the most acute critical acellular clinical syndromes which the physician and surgeon are called upon to diagnose and treat. Uncontrollable hemorrhage, a profound hemolytic anemia, or sudden sepsis, may dominate the clinical picture. An immediate and thoroughly critical blood and bone marrow study is the first essential in the differential diagnosis. There may be insufficient time for a confirmatory adrenalin test. Whether blood platelets, erythrocytes, or granulocytes, or any possible combination of these elements are found deficient in the blood stream the marrow must be hyperplastic for their precursors if and when a true uncomplicated hypersplenism is the sole cause. In such syndromes splenectomy is usually followed by a prompt and complete cellular return to normal.

### **Theory of Hemoclastic Crises**

Many theories have been advanced for the cause of the hemoclastic crises in hy-

persplenic states and have dealt mainly with congenital hemolytic icterus and idiopathic thrombocytopenic purpura. These various explanations of the cause of idiopathic thrombocytopenic purpura resolve into three principal points of view. The first, originally advanced by Frank, that the spleen depresses by some unknown method of remote hormone-like control, the megakaryocytes in the bone marrow so that they are unable to supply an adequate number of platelets.

This was confirmed by Damashek and Miller through detailed studies of bone marrow of both normal patients and those with hypersplenism. They found increased number of megakaryocytes in the marrow which were qualitatively abnormal in that they did not seem to be producing platelets. They postulated a hormonal influence of the spleen on platelet production and delivery to the blood stream. Diggs and Hewlett did similar studies on bone marrow and found the megakaryocyte counts the same in control and idiopathic thrombocytopenic purpura patients but in the controls the predominant cell was the mature megakaryocyte with active production of platelets. In the cases of thrombocytopenia the predominant cell was the intermediate cell without platelet production.

Troland and Lee reported extracts of the spleen removed from patients with thrombocytopenic purpura contained a substance, "thrombocytopen," which, when injected into experimental animals, will depress the platelet level. Doan and Wiseman, and others, were unable to duplicate these experiments and so far have failed to substantiate this work.

The alternative explanation of Doan and Wiseman is excessive destruction of platelets in the spleen. They observed excessive phagocytosis of platelets in supravital preparations of splenic tissue. The same theory is advanced by them as an explanation of primary splenic panhematopenia, hemolytic anemia, and leukopenia. Recurrences after splenectomy they believed due to accessory spleens which were not removed at the first operation.

In the syndrome of congenital hemolytic anemia again Damashek and Bloom take exception to Doan and Wiseman that the crisis is due to excessive phagocytosis of erythrocytes by the spleen. Instead they conclude that the crisis is due to a combination of (1) marked exaggeration

of the usual hemolytic mechanism with (2) arrested maturation of the erythrocytes in the bone marrow induced through a humoral factor of a pathologically hyperactive spleen. They found the marrow in crisis shows not aplasia as thought by Owren, but maturation arrest of nucleated red cells in the bone marrow at the most primitive or erythrocyte level.

Damaskek and Bloom feel the cause of spherocytosis in congenital hemolytic icterus is the result of an abnormal type of hemolytic mechanism as no evidence of spherocytosis was found in the bone marrow. They believe it is due to an isoantibody which is autospesific for cells of the patient only.

This, they believe, explained the absence of hemolysis of foreign cells introduced into patients with congenital hemolytic anemia in transfusion experiments. They feel that the spleen at times becomes unusually active and this leads to both excessive phagocytosis of spherocytes and to hypersplenic inhibitory effects upon the marrow through a humoral agent. Following splenectomy no further crises have developed.

The most recent theory is that of Evans and Duane, of Stanford University. They doubt that the macrophages of the spleen have capacity to ingest and digest sufficient amounts of cellular elements to produce a severe panhematopenia in view of the functional capacity of the spleen. The suggestion by Doan that an accessory spleen of a few grams of tissue is capable of the same thing is less plausible. The formation of an antibody like substance which they have demonstrated in acquired hemolytic anemia is felt to be the cause of the hypersplenic syndromes. The exact nature of this hemolysis is unknown but it has been observed in acquired hemolytic anemia even in remission. The immediate effect of splenectomy appears to be brought about by the reduction of the amount of sensitizing agent on the cell. This suggests that the spleen is the principal site of production of the sensitizing agent. The failure of splenectomy to produce remission in some patients is evidently due to the production of sufficient hemolysin in other lymphatic and reticuloendothelial tissues of the body to keep the disease active.

The exact nature of the hemolysin is not clear. The chief question seems to be whether or not it is a true immune body or some entirely different, as yet un-

known, type of variant of normal plasma protein.

Evans and Duane postulate that the same mechanism found in acquired hemolytic anemia may be operating in thrombocytopenic purpura and splenic neutropenia. The effect of splenectomy in acquired hemolytic anemia and thrombocytopenia is uncertain. It is usually beneficial to some degree but in only one-half to two-thirds of the patients is remission complete. Relapse after remission has been observed in both groups of patients.

Abnormal immune mechanisms could account for both excessive destruction and deficient formation. Sensitized platelets may be susceptible to agglutination and phagocytosis and the presence of an antiplatelet antibody in the circulation may damage the cytoplasm of the megakaryocyte so as to inhibit the formation of platelets.

#### Recurrences After Splenectomy

As stated above one-half to two-thirds of the patients with hypersplenism receive total and complete remission with splenectomy. Those that do exhibit a recurrence sometimes involve the same type of cell and at others a different type of cell than was originally destroyed. Doan and Wiseman feel that the presence of accessory spleens is the principal agent. Damaskek and Miller tend to agree with this theory also. However, Doan himself admits that an occasional case of recurrence or post splenectomy failure may be due to generalized nonsplenic reticuloendothelial cell hyperplasia and hyperphagocytosis. The element of antibody reaction as postulated by Evans and Duane and discussed above is to be considered.

#### Contraindications to Splenectomy

It is worth while to mention at this time the contraindications to splenectomy. These include: any acute or chronic marrow damage, myelofibrosis, and osteopetrosis in which splenomegaly is usually a focus of ectopic hematopoiesis, panmyelophthisia, and ectopic splenic hematopoiesis plus secondary hypersplenism.

#### Summary and Conclusion

Primary hypersplenism must be considered in any case which demonstrates either anemia, thrombocytopenia, granulocytopenia, or any combination of these findings in the peripheral blood, when



the bone marrow appears hyperplastic for the involved elements and there is no evidence of leukemia in the bone marrow or peripheral blood. Secondary hypersplenism must be considered in the course of a number of diseases when a hemoclastic crisis develops.

The mechanism of the hypersplenic syndrome and hemoclastic crises has been discussed and the various theories presented. At the present time they separate into three principal viewpoints. The first, of Frank, Damashek, and others, maintains that the bone marrow is inhibited in formation or delivery of mature cells or platelets by a hormonal influence of the hyperactive spleen. The second, of Doan and his group, postulates that the hyperactive spleen is the sole cause through hypersequestration, stasis, and phagocytosis by the reticuloendothelial cells of the circulating elements of the blood. The third and most recent, of Evans and Duane, proposes an antibody like substance produced by the spleen which makes the circulating element of the blood more susceptible to destruction in the spleen and perhaps the antibody also plays a role in deficient formation. Evans and Duane indicate also that the failure of splenectomy to produce remission in one-third of the cases may be due to the formation of sufficient hemolysins in extrasplenic reticuloendothelial tissues of the body to keep the disease active.

One would surmise that a complex mechanism is operating in this syndrome which probably is a combination of all three theories but in any case the spleen is incriminated as the disturbing element, and primary site of disease.

The present feeling that congenital and acquired hemolytic anemia, idiopathic thrombocytopenic purpura, primary splenic neutropenia, and panhematocytopenia are all related in some way with a hyperactive spleen is discussed.

As so clearly stated by Kracke and Riser, the basic problem in hypersplenism for any patient is first whether or not the spleen is destroying more cells than

normal, and second whether or not the bone marrow is capable of producing the normal number of cells to support that particular patient, and then decide whether it is safe to leave the spleen within the patient or risk the operation to remove it.

The best clinical judgment in most groups which have studied this disease has been more frequently than not to eliminate the focus of disease in the spleen. Only if the spleen is serving as an ectopic hematopoietic focus will the patient be less well off without the spleen.

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## THE RATIONALE OF THE MODERN DIAGNOSTIC APPROACH TO MEDIASTINAL TUMORS

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The proper management of a mediastinal tumor depends upon a proper evaluation of the lesion. A wholly accurate diagnosis is not demanded. By a systematic method of diagnostic approach a mediastinal tumor can be sufficiently evaluated so that a reasonable therapeutic program may be outlined. Interest in tumors of the mediastinum has undergone a considerable evolution during the past two decades. These tumors are no longer being considered purely of academic interest. We have now reached an era of thinking in relation to these lesions in which one little hesitates to recommend a surgical exploration of this region of the body. Most benign tumors of the mediastinum can undergo rapid cure by surgical excision. Increasing success is being obtained by surgical excision of malignant tumors arising in this area. These tumors, then, demand an accurate evaluation. Certain lesions are not candidates for surgical intervention. The tumors requiring surgery demand that a sufficient evaluation of them be obtained prior to operation so that a properly planned operation can be carried out. It is with these considerations in mind that it is felt worthwhile to evaluate the methods of diagnostic approach available to us relative to lesions of the mediastinum.

### The Topographic Divisions of the Mediastinum

In order to understand properly the mediastinum, one must appreciate both its anatomy and its physiology. Several excellent classifications of the areas of the mediastinum have been described. However, it appears that the most practicable outline of the anatomical divisions involved is that method which can be most readily applied to the lateral X-ray view of the mediastinum. Major attention is given to this projection since this is the X-ray picture which visualizes the greatest single expanse of the mediastinum. The classification preferred for this topo-

graphical anatomy of the mediastinum is presented in Chart I. The divisions of the mediastinum are outlined as well as the boundaries of these separate areas. The normal content of each of these mediastinal segments is presented in the four following figures, namely Charts II, III, IV, and V. Attention is drawn to the constant and inconstant contents of these divisions.

The lymphatic system as it is presented in the mediastinum is subject to considerable variation in different individuals. However, it is of fundamental importance to realize that the major areas of lymph node concentration occur in the right paramediastinal portion of the superior mediastinum and in both hilar regions. In order to apply this knowledge to the X-ray studies it is well to describe the location of the lymph nodes in a further manner. The lymph nodes of the mediastinum occur predominantly in contiguity with the superior vena cava, the right lateral border of the trachea, both mainstem bronchi, and the pulmonary arteries and veins just as these structures leave the confines of the pericardium. It is very important that this usual concentration of lymph nodes be appreciated whenever we consider mediastinal tumors since in all mediastinal tumor diagnoses one must consider the

### DIVISIONS OF THE MEDIASTINUM

- I. SUPERIOR MEDIASTINUM  
Space between thoracic inlet and aortic arch
- II. ANTERIOR MEDIASTINUM  
Space between aortic arch, sternum, pericardium and diaphragm  
(Anterior boundary extends laterally to costochondral junction)
- III. MIDDLE MEDIASTINUM:  
Pericardium and its contents
- IV. POSTERIOR MEDIASTINUM  
Space between aortic arch, pericardium, diaphragm and vertebra  
(Posterior boundary extends laterally to angle of ribs)

### CHART I



**CONTENTS OF MEDIASTINAL DIVISIONS****I. SUPERIOR MEDIASTINUM****A. CONSTANT**

1. Upper thoracic sympathetic chain.
2. Thoracic duct
3. Esophagus
4. Great vessels to head and upper extremities
5. Upper thoracic portion vagus nerves.
6. Trachea

**B. INCONSTANT**

1. Substernal or ectopic thyroid tissue
2. Developmental cysts
3. Ectopic tissue

**CHART II****II. ANTERIOR MEDIASTINUM****A. CONSTANT**

1. Thymus
2. Internal mammary vessels
3. Phrenic nerves
4. Lymph nodes in posterior portion.

**B. INCONSTANT**

1. Teratoma
  - a. Benign or dermoids
  - b. Malignant
2. Ectopic tissue

**CHART III****III. MIDDLE MEDIASTINUM****A. CONSTANT**

1. Pericardium
2. First 2 cm. innominate artery.
3. Ascending aorta
4. Pulmonary artery, first portions right and left pulmonary arteries
5. Heart
6. Autonomic nerves to heart

**B. INCONSTANT**

1. Transverse portion aortic arch
2. First part left common carotid and/or left subclavian
3. Ductus arteriosus, patent or obliterated

**CHART IV****IV. POSTERIOR MEDIASTINUM****A. CONSTANT**

1. Sympathetic nerves
2. Vagus nerves
3. Thoracic duct
4. Esophagus
5. Both mainstem bronchi
6. Hilar lymph nodes - situated anteriorly
7. Hilar vessels
8. Inferior vena cava

**B. INCONSTANT**

1. Developmental cysts
2. Ectopic tissue

**CHART V**

possibility of lymph node pathology. However, the possibility that the lesion is of primary lymph node origin greatly decreases as one leaves the areas of usual major concentration of lymph nodes.

A further important consideration in relation to the mediastinum is the realization that it is a midline structure. Midline structures notoriously tend to contain inconstant elements, elements resulting from faulty embryological development. These inconstant elements may occur in any division of the mediastinum. Experience has shown that there is a much greater tendency for dermoid cysts to appear in the anterior mediastinum, while bronchogenic and gastric cysts are somewhat more prone to appear in the posterior mediastinum. There is no constancy of such inconstant elements, as they can appear in any division. The schematic division outlined for the mediastinum is considered the main foundation stone for the systematic diagnostic approach to mediastinal tumors.

**Types and Incidence of the Lesions to be Considered**

If we were to confine the discussion purely to the lesions arising within the substance of the mediastinum, a large number of lesions would need to be considered. An enumeration of the possible lesions which may arise within the mediastinum is presented in Chart VI. However, this long list does not include all the lesions which must be considered in the differential diagnosis when one is confronted with a mediastinal shadow. Unfortunately, lesions arising in the paramediastinal area must be kept constantly in mind in any diagnostic approach to the mediastinum. An outline listing of the paramediastinal lesions which must be kept in mind is present in Chart VII.

Mediastinal lesions fall into three essential categories. First, there are those lesions arising in tissues not normally present in the mediastinum which we classify as ectopic and congenital in origin. Second, there are the lesions of neoplastic type, both benign and malignant. In the third, and final category, are grouped the diseases of inflammatory, traumatic, or degenerative etiology.

One of the practical factors in differential diagnosis is a proper appreciation of the relative incidence of different types of pathology. Mediastinal tumors of different kinds can directly imitate each

other, both in regard to symptoms, physical findings and X-ray appearance. Certain areas of the mediastinum are most prone to contain certain lesions, and these are outlined in Chart VIII. A dermoid cyst, a gastric cyst, a bronchogenic cyst, a malignant teratoma, a substernal thyroid, and a neurofibroma can present quite similar X-ray appearances. Yet, each has a distinctly greater tendency to occupy its own individual area of the mediastinum.

#### TYPES OF MEDIASTINAL TUMORS

##### I. SUPERIOR MEDIASTINAL DIVISION

###### A. Ectopic tissues (including congenital defects)

1. Thyroid: adenomas, cysts, malignant tumors
2. Diverticula: pharyngeal and esophageal
3. Parathyroid: adenomas, cysts, malignant tumors
4. Vascular: aneurysms and angiomas.
5. Congenital cysts: bronchogenic, gastrogenous, coelomic

###### B. Neoplastic causes (benign, malignant or metastatic types possible)

1. Neurogenic tumors
2. Thymic tumors: (including benign hypertrophy)
3. Lymphatic tumors: lymphomas and lymphangiomas
4. Vascular tumors

###### C. Inflammatory, Traumatic and Degenerative Causes

1. Lymphadenitis (including the granulomatous diseases)
2. Abscesses: secondary to Pott's disease dorsal spine: from perforations esophagus or bronchi
3. Vascular: aneurysms, hematomas

#### CHART VI

##### II. ANTERIOR MEDIASTINAL DIVISION

###### A. Ectopic tissues (including congenital defects)

1. Congenital cysts: benign teratoma (dermoid) coelomic cysts
2. Parathyroid adenomas
3. Diaphragmatic hernia: (foramen of Morgagni)

###### B. Neoplastic causes (benign, malignant or metastatic)

1. Teratoma (malignant)
2. Thymic tumors
3. Lymphatic tumors

4. Neurogenic tumors (may be "dumb-bell" type)
5. Lipoid tumors
6. Osseous and cartilagenous tumors (frequently metastatic)

###### C. Inflammatory, traumatic or degenerative causes

1. Lymphadenitis (including granulomas)
2. Abscesses: (rare) either traumatic or lymphogenous
3. Vascular: aneurysms, hematomas

#### CHART VI a

##### III. MIDDLE MEDIASTINAL DIVISION

###### A. Congenital Abnormalities: heart, pericardium, great vessels

###### B. Neoplastic Causes: (Metastatic tumors more common)

1. Pericardial tumors
2. Heart wall tumors

###### C. Inflammatory, traumatic, or degenerative

1. Abscesses: pericardium, pericardial space, heart wall
2. Vascular: enlargement cardiac chambers: aneurysm hematomas

#### CHART VI b

##### IV. POSTERIOR MEDIASTINAL DIVISION

###### A. Ectopic tissues (including congenital defects)

1. Congenital cysts: bronchogenic, gastrogenous, coelomic, dermoid and chylous
2. Diverticula of esophagus reduplication esophagus or stomach
3. Diaphragmatic herniae (hiatal or aortic foramina)
4. Meningocele

###### B. Neoplastic causes (benign, malignant, or metastatic types)

1. Teratomas
2. Lymphatic
3. Neurogenic
4. Esophageal
5. Vascular
6. Lipoid
7. Osseous (usually benign)

###### C. Inflammatory, traumatic or degenerative

1. Lymphadenitis (including the granulomas)
2. Abscesses: secondary to Pott's disease dorsal spine: from perforations esophagus or bronchi
3. Vascular: aneurysms hematomas

#### CHART VI c



**TYPES OF PARAMEDIASTINAL MASSES**

- I. LESIONS OF PLEURA OR PLEURAL SPACE
  - A. Loculated fluid (clear, hematoma, or empyema)
  - B. Invasive tumor of pulmonary origin
  - C. Primary tumor of pleura (rare)
- II. PRIMARY PULMONARY LESIONS
  - A. Malignancies lung and bronchi
  - B. Metastatic pulmonary tumors
  - C. Inflammatory lesions
  - D. Pulmonary vascular lesions
- III. LYMPHATIC ORIGIN
  - A. Peribronchial nodes
- IV. ECTOPIC TISSUE
  - A. Diaphragmatic herniae
  - B. Eventration diaphragm
  - C. Congenital cysts

**CHART VII a****CAUSES OF COMBINED MEDIASTINAL AND PARAMEDIASTINAL MASSES**

- I. PULMONARY MALIGNANCIES
- II. LYMPH NODE DISEASES
  - a. Lymphomas
  - b. Granulomas
- III. ANEURYSMAL DILATATIONS
  - a. Pulmonary arteries
- IV. TRAUMATIC

**CHART VII b****The Clinical Significance of Potential of Mediastinal Masses**

As our information grows, we are becoming increasingly impressed with the serious potential inherent upon mediastinal tumors. Unfortunately, a fairly large percentage are primarily malignant. Experience has shown that the most common malignant tumors of the mediastinum belong to the lymphoma group including such diseases as lymphosarcoma, Hodgkin's disease, leukemia, etc. There are other primary malignant tumors arising in this region. We see malignant teratoma, sympathicoblastomas, and other, but fortunately less common primary malignancies.

Inasmuch as the mediastinum is such a vital area it is distinctly rare that a lesion of any type cannot present a serious threat to the patient's existence or to the health of all or part of an important organ. Small benign tumors can progress in size until they produce a major disturbance of circulation or of respiration. If properly situated they can constitute a considerable hazard to nutrition by obstruction of the esophagus. Furthermore, it appears that any tumor mass, no matter how be-

nign it appears, may under certain circumstances undergo transformation into a malignant growth. Only too frequently do we see the posterior mediastinum's most common tumor, the neurofibroma, after it has undergone areas of sarcomatous degeneration. In a similar manner, the anterior mediastinum's most common tumor, the dermoid cyst, may be allowed to progress until it has undergone disruption of its capsule and carcinomatous or other types of malignant degeneration. The old adage of "the lack of malignant degeneration" in substernal thyroid adenomata has repeatedly been proven false.

**MOST COMMON LESION IN EACH MEDIASTINAL DIVISION**

(Solitary Division Involvement)

- I. SUPERIOR MEDIASTINUM
  - A. Substernal Thyroid
  - B. Pharyngeal diverticulum
  - C. Granuloma
- II. ANTERIOR MEDIASTINUM
  - A. Dermoid cyst
  - B. Thymid tumor
  - C. Lymphosarcoma
- III. MIDDLE MEDIASTINUM
  - A. Enlarged Heart Chamber
  - B. Aneurysm
    1. Aorta
    2. Pulmonary artery
- IV. POSTERIOR MEDIASTINUM
  - A. Neurofibroma
  - B. Aneurysms
  - C. Lymphosarcoma

**CHART VIII a****LESIONS INVOLVING COMBINED DIVISIONS OF MEDIASTINUM**

- I. ANTERIOR AND POSTERIOR DIVISIONS
  - A. Lymphomas
  - B. Metastases
- II. ANTERIOR AND SUPERIOR DIVISIONS
  - A. Thymus lesions
  - B. Teratomas
- III. ANTERIOR, SUPERIOR, AND POSTERIOR DIVISIONS
  - A. Lymphomas
  - B. Sarcoid
- IV. POSTERIOR AND SUPERIOR
  - A. Aneurysms
  - B. Megaesophagus
- V. POSTERIOR AND MIDDLE
  - A. Aneurysms
- VI. SUPERIOR AND MIDDLE
  - A. Aneurysms

**CHART VIII b**

As has been mentioned, these lesions may threaten either the existence of the individual or the future health of an adjacent organ. Major compression by a mediastinal tumor may result in permanent destruction of a portion of the lung due to vascular and bronchial disturbances decreasing that area's resistance to infection. A gross example of this is the so-called "aneurysmal tuberculosis." By this is meant the recrudescence or reactivation of an apparently healed pulmonary focus in response to compression of the bronchus and pulmonary vascular bed by an aortic aneurysm.

Vascular abnormalities such as aneurysms constitute a relatively large proportion of mediastinal lesions, and the dangers inherent upon such lesions are common knowledge.

Not only can mediastinal tumors play a role in the production of infection in adjacent organs, but the mediastinal lesion itself may either be primarily inflammatory or become infected. It is hardly necessary to discuss the potential of mediastinal granulomas such as a tuberculoma. Certain congenital cysts may become infected and by this infection present a serious hazard to the patient's health and existence. This is particularly prone to occur in lesions having a communication with an organ of the body which in turn has contact with either the inspired air or ingested food or fluid. Thus, a bronchogenic cyst arising in a mediastinal position may undergo serious inflammatory change. A large diverticulum of the esophagus, an area of reduplicated esophagus, or a gastrogenous cyst can demonstrate serious inflammatory complications.

In summary then, we must concede that any mediastinal lesion presents an inherent serious potential. If this be true, then every mediastinal lesion, no matter what its size, has an important clinical significance.

### **The Methods of Diagnostic Approach to Mediastinal Tumors**

The basic methods of diagnostic approach are, of course, the same in regard to the mediastinum as they are to other areas of the body. The area involved, however, is large and in some ways remote. Only a very small portion of this area of the body comes in contact with peripheral nerves. This predicts that the symptomatology in this area must be vague and, in many instances, actually

indirect. The mediastinum is protected by bone and difficult of access in regard to the usual methods of physical diagnosis. Again, we have the prediction, therefore, that the physical findings may be vague or indirect. It is the author's contention that as new methods of physical examination are developed and as a new interest in mediastinal symptoms is aroused, many of the concepts at present relative to the symptomatology and physical diagnosis of mediastinal tumors will be changed. From the practical aspect today, we must admit that our major methods of diagnosis consist of the X-ray approach and its modifications. Basic methods of approach available for studying tumors of the mediastinum are outlined in Chart IX. It is our intention to discuss briefly each of these methods and analyze the efficiency and limitations of each method as a diagnostic measure.

### **Symptomatology Presented by Tumors of the Mediastinum**

The accepted premise relative to tumors of the mediastinum states that these tumors of themselves do not present symptomatology unless by their size or position they are able to create a major disturbance upon the cardiovascular bed, the respiratory tract, or upon a peripheral nerve. These assumptions are supposed to hold both in regard to benign tumors and to malignant lesions. I believe that we are now obtaining evidence which

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### **METHODS OF INVESTIGATION OF MEDIASTINAL MASSES**

- I. SYMPTOMS
- II. PHYSICAL EXAMINATION
  - a. Lymphatic system, including liver and spleen
  - b. Autonomic nervous system
  - c. Vascular system
    1. Blood pressure
    2. Venous pressure
    3. Collateral
  - d. Respiratory system:
    1. Bronchial compression
- III. LABORATORY STUDIES
  - a. Blood
  - b. Urine
- IV. X-RAY STUDIES
- V. CARDIAC CATHETERIZATIONS
- VI. DIRECT EXAMINATION
  - a. Thoracoscopy
  - b. Exploratory thoracotomy

### **CHART IX**



shows that this premise or assumption is not wholly correct.

The transmission of sensations to the higher levels of the cerebral cortex by stimulation of the peripheral sensory nerves is a thoroughly accepted fact and observation. For some strange reason, there has been a prolonged contention in medicine that the autonomic nervous system does not transmit sensations to the higher levels of consciousness. Evidence is now accumulating which suggests that this latter is a totally unacceptable premise. The severe constrictive sensations of pain associated with acute occlusion of coronary artery blood flow have in certain instances been completely interrupted by removal of certain of the upper dorsal sympathetic ganglia. Drs. Curtis and Klassen have very beautifully demonstrated the sensory component of the vagus nerve in regard to the tracheo-bronchial tree. All of us in thoracic surgery who have been indulging in denervation procedures relative to the lung have become tremendously impressed with the sensory component, the sensations carried by the afferent fibers, of both the sympathetic and the parasympathetic system. The gastro-enterologists tell us that certain patients undergoing vagotomy for gastro-intestinal tract disease have complained about a certain lack of sensations which they enjoy prior to the operation. Peptic ulcers may perforate painlessly following transection of the parasympathetic nerves. As long as a mediastinal tumor remains within the confines of the mediastinum, the patient's symptoms must depend upon disturbances of nerves traversing through the mediastinum or by the effect of the lesion upon the cardiovascular bed, respiratory tract, or the esophagus.

Five years ago we became impressed by the occasional bizarre symptom described by a patient with an intrathoracic lesion, a symptom which in itself practically outlined the size and character of the lesion harbored by the patient. A few experiences of this type soon impressed us with the intelligence of the autonomic nervous system in certain patients. Following a period of such thinking our initial plan was to test this premise by obtaining the maximum amount of information, no matter how apparently bizarre, from a patient prior to excision of any mediastinal tumor. The patient was then re-examined at specific intervals following the excision of the mediastinal tumor to discover what

sensations present prior to the operation had now disappeared. The patients were also interrogated at length at intervals following their surgery in regard to any sensations present prior to operation about which we had not asked but which were no longer present. As this knowledge increased, we began to be able to ask direct and important questions of patients at the time of their initial visit and discover symptoms which apparently can be produced by lesions, lesions we were taught to consider "non-symptom-producing lesions." In order to emphasize this point I would like to describe in detail a single patient sent in to us with the description by her physician that "a totally asymptomatic lesion" had been discovered upon screening X-ray examination. Our investigation could not confirm this premise of a lack of symptomatology. As the combined interview with the patient and her husband progressed both these individuals volunteered that they could not understand how her tumor could have been described as being completely free of symptoms.

### Case History

Patient, Mrs. E. J. W.: 30-year old white female. Referred to the Chest Division because of "a large, totally asymptomatic mediastinal tumor." The history was taken jointly from the patient and her husband. As the family was interrogated the following story was evolved. For approximately 12 to 14 months the husband has been conscious of his wife's breathing when she was asleep, and felt that she breathed more rapidly and louder than he did. He is also conscious that for a little longer period than this she appears to become dyspnoeic more rapidly than he on approximately equal effort. For from three to six months the patient has noted some discomfort in her chest which is "hard for her to define." This sensation consists, mainly, of a localized tiredness. She localizes this in the left interscapular region. It is aggravated by effort. For five to six months she has been conscious of episodes of tachycardia without apparent cause, sufficient to ask her husband to feel and count her heartbeat. For three to four months she has noted that when she lies on her left side she has a sensation which makes her wonder if she might strangle to death, because of inadequate ability to breathe if she insisted on lying in this position. Relief is obtained upon lying on the right side.

Such relief is almost immediate.

For one year patient has also noted that she experiences peculiar feelings in both wrists and hands, particularly with fatigue; they become numb; they have become sensitive to changes in temperature. She has noted some easy fatigability which, she believes, has only occurred during the past month and has been associated with some anxiety brought on by a knowledge of the presence of this tumor. The objective findings noted by the husband occurred prior to any knowledge of the tumor. The husband volunteered that the patient had complained, spontaneously, of the abnormal chest sensations, the bizarre changes in the sensitivity of the upper extremities to temperature change, and the discomfort in the hands and wrists long prior to any knowledge of the mediastinal tumor. The episodes of tachycardia and complaint of a vague, localized discomfort in the left interscapular area had been volunteered, by the patient to her husband, prior to any knowledge of the existence of the tumor.

At the completion of the interview the patient and her husband spontaneously remarked, "it would appear to us that she has been having difficulty for the past year and that these difficulties are most probably related to the presence of this tumor." This tumor proved to be a neurofibroma arising in the left posterior mediastinum producing considerable pressure upon the descending thoracic aorta, left lung, and dorsal sympathetic chain.

This is far from an isolated instance. Detailed description of the bizarre symptoms presented by tumors in the mediastinum and elsewhere in the thorax, does not appear justified in this presentation. Briefly in our experience we find that the most common unusual symptom in a neurofibroma is a localized area of easy fatigue or "tired discomfort" in the involved interscapular region. The tumors of the lymphoma group appear to produce a peculiar, localized stinging, or burning, sensation. The cystic tumors of the anterior mediastinum tend to be associated with the complaint of a feeling of internal swelling. Tumors in the superior mediastinum have shown a tendency to produce a vague, poorly localized discomfort in the involved shoulder and neck region. This has frequently been described to us by the patients as a sensation of "tiredness" in the involved area. Malignant tumors of the thymus invading the ad-

ventitia of the ascending aorta have been noted to simulate a chronic type of pain comparable in distribution to that in acute episodes of coronary occlusion or angina pectoris.

Because of our interest in this aspect of the problem, we could easily discuss it at unwarranted length. It is too soon to know of what importance these symptoms apparently arising from an intelligent autonomic nervous system, will assume. First, they must be more completely understood and information about them portrayed to the profession. They are not symptoms which the average patient will volunteer. As the laity gradually learn that such symptoms exist, the patients will be more willing to describe these sensations to us and be less afraid of being falsely accused of being psychoneurotic individuals. Under any circumstances this aspect of the diagnostic problem is mainly one of interest for the future and is discussed in hopes that other investigators will try to evaluate the importance of these sensations. As a physician's knowledge of these sensations increases this aspect of the diagnostic approach to mediastinal tumors does increase in interest and importance.

#### **The Role of the Physical Examination in the Study of Mediastinal Lesions**

Again, when one wishes to discuss this aspect in the study of tumors of the mediastinum there appears to be a shocking lack of physical findings in many instances. It is felt, strongly, that as greater interest is paid to tumors of the mediastinum, new and improved methods of physical diagnosis will appear. One of the main factors in describing the diagnostic approach as it exists today, is the emphasis that must be laid upon the limitations of the value of the history and the physical examination.

One may theorize as to the methods of production of physical signs by lesions of the mediastinum, and with applications of these theoretical principles improved methods of diagnosis may be developed. Peripheral nerves come in contact with the mediastinum in its lateral posterior extremity as the intercostal nerve root comes out of the intervertebral foramen. The intercostal nerves again come in continuity with the mediastinum in its anterior lateral projection at the under surface of the sternum and costocartilages. The sensory and motor nerve pathways



most exposed to disturbance by mediastinal tumors are the sympathetic nervous system, the vagus nerves, and the phrenic nerves. The major portions of the vascular bed which may be disturbed are, (1) the heart, (2) the aorta, (3) the pulmonary artery, (4) the innominate, right and left subclavian, and both common carotid arteries, and (5) the venous system as manifested by the inferior and superior vena cava, both innominate veins and azygous vein.

It is felt rational, therefore, that the major factors in the physical examination of the mediastinum should consist of an intimate attention to effects upon the vascular bed, the nervous systems involved and to one other major factor, namely, the lymphatic system.

Therefore, it is felt that the physical examination must be directed toward the vascular system in the following manner. There must be a routine study of the blood pressure in each of the upper, and in at least one of the lower extremities in all patients suspected of harboring mediastinal tumors. One must note effects upon the heart such as displacement, cardiac compression, or abnormality of cardiac rhythm. Considerable attention is paid to any visible disturbance of the venous circulation. The possibility of unusual collateral arterial circulation is an important consideration. The fullness of the neck veins and the presence of abnormal venous collateral circulation are constantly investigated. Venous pressure is measured in both upper extremities. Partial obstruction of the vena cavae is determined by measuring the effect of hand exercise and abdominal compression. The circulation time should be evaluated through each antecubital vein.

Attention is paid to possible effects of mediastinal tumors upon the various nervous systems. Thus, mediastinal tumors may produce a partial or complete Horner's syndrome, a disturbance in sweating over any of the dermatomes regulated by the thoracic sympathetic ganglia. Either of the autonomic nervous systems may produce an abnormal cardiac rhythm or an abnormal response of the heart to strain. A paralysed vocal cord may be produced if a tumor presses upon a recurrent laryngeal nerve. Effects upon the peripheral nerves may be present. Sensory or motor changes resulting from disturbance of an intercostal nerve must be considered. Certain lesions in the

superior mediastinum may affect the brachial plexus.

The major attention of the physical examination in relation to tumors of the mediastinum, has always seemed to be placed upon the lymphatic system. Certainly a complete observation and palpation of all superficial major lymph node areas, as well as the liver and spleen, are demanded in any examination of the mediastinal tumor patient.

One next pays particular attention to the respiratory tract. Any evidence of abnormal dullness or flatness to percussion is considered. Variance in mobility of intercostal spaces is noted. Auscultation is carried out in particular detail to determine any areas of possible extrinsic compression upon the airway so that rales or wheezes are presented. Frequently a mediastinal tumor may only produce compressive factors discernible on auscultation if the patient is placed in certain positions. Frequently a clue to this position may be obtained by asking the patient in regard to the positions which produce respiratory discomfort, vague uneasiness, or wheeze.

In summary, then, the physical examination may show very little in the way of positive physical findings. However, it is felt that any complete physical examination should include bilateral evaluation of the blood pressure, distinct attention to disturbances in venous circulation in the upper and lower extremities, palpation for possible variance in body heat or sweating in the various dermatomes related to the mediastinum, and evidences of bronchial compression. Paralysis of the phrenic nerve may sometimes be discovered by percussion and by auscultation. Fortunately, the physical findings suggested may all be confirmed by further tests such as measurements of venous pressure, visualization of the venous channels by diodrast. Blood pressure abnormalities may be confirmed by oscillographic readings. Special skin temperature studies may confirm the impressions relative to body surface heat disturbance. The iodine-starch test will aid in confirming evidence of disturbance of sweating in the various dermatomes. X-ray and fluoroscopy will help to confirm the findings apparent in regard to bronchial compression or disturbances of the phrenic nerve.

It is felt that physical findings will as-

sume a greater importance in the diagnostic regimen involved relative to tumors of the mediastinum as greater attention is paid to this aspect of the lesions. Certainly, to obtain the maximal understanding relative to the physiopathology of tumors of the mediastinum, we should be able to have a situation wherein the physical findings confirm the findings of X-ray, and the patient's symptoms confirm the findings both of X-ray and of the physical examination.

#### **Laboratory and X-Ray Methods of Investigation of Tumors of the Mediastinum**

The laboratory studies required in all patients suspected of harboring mediastinal tumors include a careful examination of the blood and a serological test for syphilis. The blood examination must include a very careful differential smear to evaluate the possibility of any blood dyscrasia. The sedimentation rate has been found, in our experience, to be of relatively little value in these lesions, as it may be elevated or low in the presence of either benign or malignant tumors. Of course, if the differential smear suggests the possibility of blood dyscrasia, further special examinations in the field of hematology would be indicated. Such examinations consist of biopsies of the lymph nodes and studies of the sternal bone marrow. The urine examination rarely defines anything unusual in the presence of mediastinal tumors. A Sulkowitch test is recommended if parathyroid adenoma is suggested by clinical behaviour. Specific hormone assay of the urine may be indicated in the presence of certain anterior mediastinal tumors but it is felt that this procedure is of relatively little practical value. In lesions involving the lymph nodes special studies may be required, such as tuberculin tests, skin tests for sarcoid, certain complement fixation and agglutination tests.

#### **The Methods of X-Ray Investigation**

The most dramatic findings in regard to mediastinal tumor certainly appear following X-ray investigation. This is the major factor at present time utilized in the evaluation of these tumors. The methods of available X-ray investigation of these lesions are listed in Chart No. X.

Certain absolute fundamentals are needed by every mediastinal tumor in regard to required X-ray studies. To examine the mediastinum by X-ray demands, first, a combined P. A. and lateral projection

### **METHODS OF X-RAY INVESTIGATIONS**

- I. FLUOROSCOPY
- II. VARIOUS DIRECTIONAL FILMS
  - a. P-A and lateral, mandatory
- III. CONTRAST METHODS
  - a. Barium - esophagus, upper and lower G. I. tract
  - b. Air - as pneumothorax or pneumoperitoneum
- IV. LAMINOGRAPHY
- V. ROENTGEN-KYMOGRAM  
(rarely valuable)
- VI. STEREOSCOPIC VIEWS  
(rarely valuable)

#### **CHART X**

roentgenogram and, second, a very thorough fluoroscopic examination. The P. A. and lateral X-rays are required to give us a three dimensional examination of the area involved.

The fluoroscopic examination allows us to study the mediastinum during function. In particular, it allows us to see the changes in the size of a mediastinal lesion during the phases of respiration. The mediastinum widens during expiration and considerably narrows during inspiration. It thus places lesions in a different relief, and a lesion poorly visible in one phase of respiration may become strikingly prominent in the other phase of the respiratory cycle. Fluoroscopy, of course, also allows us to see the patient in multiple projections during variable phases of respiration. It allows us to test the Val Salva reflex and thus helps us to estimate potential disturbance of the vagus nerve in its upper portion. The fluoroscope demonstrates the presence or absence of paralysis of a phrenic nerve. It is also used to help visualize the pulsating character of a mediastinal lesion. It does not necessarily tell us whether the pulsation is intrinsic or transmitted, as this differentiation can only be determined by the use of the angiocardiogram.

The use of a barium swallow is an absolute necessity in any fluoroscopic examination of the lungs, mediastinum, or heart. The esophagus has a certain tendency to behave in a different manner in relation to different types of mediastinal tumors. The multiple metastases in mediastinal glands, as may occur from a primary carcinoma of the lung, transforms the esophagus into a rather rigid organ with multiple indentations. A tumor of the anterior mediastinum which is exerting increasing pressure may cause the left



mainstem bronchus to press against the esophagus and produce a step-like delay in the passage of barium. We are all familiar with the indentation produced upon the esophageal wall by a large tortuous aorta. In our experience no lesion so distorts and displaces the esophagus as does an aneurysm of the aorta. The esophagogram also allows us to study variations in structures within the middle mediastinum, especially enlargement of the left auricle. Furthermore, the esophagus itself may be the source of the mediastinal tumor. Thus, a megaesophagus producing a very large distortion of the mediastinal pattern is beautifully demonstrated upon ingestion of barium. A posterior paramediastinal tumor mass may be produced by a massive diverticulum of the esophagus.

Benign tumors of the esophageal wall, such as a leiomyoma, may only be discovered by visualization of the esophagus. Furthermore, the barium swallow must be studied not only in the upright, but also with the patient lying flat, and with the patient in the Trendelenburg position, if we are going to rule out the possibility of hiatus hernia or other diaphragmatic herniae containing the stomach.

With the eyes well accommodated, fluoroscopic examination allows us to determine the relative ability of the two lungs and portions of each to evacuate their contained air on expiration. Our experience has shown that a mediastinal lesion causing bilateral respiratory obstruction is most liable to be an aortic aneurysm or a lymphoma.

Paralysis of the phrenic nerve is a very significant finding on fluoroscopic examination. It is interesting to note how extremely rarely this phenomenon is produced in the presence of mediastinal tumors of the lymphoma group. In our experience the two lesions most prone to produce this phenomenon are, (1) mediastinal metastases from carcinoma of the lung, and (2) aneurysms of the aorta and great thoracic vessels. This type of paralysis has also been described not infrequently in association with mitral stenosis and enlargement of the left auricle.

In summary, then, fluoroscopic examination is one of our most cardinal needs in the X-ray evaluation of the mediastinum. Fluoroscopy, in conjunction with the P. A. and lateral X-rays, gives us the most important clues toward prescribing

what further special X-ray studies may be required.

### Special Methods of X-Ray Examination

**LAMINAGRAPHY:** In previous communications upon this subject we have laid our major emphasis upon the importance of the use of contrast media in the study of mediastinal tumors. The important place of the contrast medium of barium in the esophagus is felt to be unchanged. The need for the use of air and diodrast as contrast media, we feel, is becoming less frequently required as we increase our experience with the laminagram or planigram method of investigation. It is too soon to be certain in regard to the relative importance of these different methods but it is certainly hoped that the laminagram will have increasing importance, inasmuch as it is completely free of risk in contradistinction to the small but definite risk involved when one uses either air or diodrast methods of contrast study.

Considerable application of planography to the study of mediastinal lesions, and lesions throughout the thoracic cavity, has been carried out at Emory University Hospital through the intensive interest of Dr. Ted F. Leigh. Detailed reports in this regard will be forthcoming from him. At the present time we perform laminagraphy in the study of every mediastinal tumor, in order to evaluate, properly, the place of this method of examination. In some instances it has been of startling value. It appears to be particularly helpful in the study of mediastinal lesions, in determining between the vascular and avascular source of the mass. This method of examination frequently defines areas of calcification in the wall of an aneurysm not seen on the ordinary film. In some instances it may show a continuance of wall calcium deposition from an aneurysm into the wall of the mother vessel, namely, the aorta. It has been particularly helpful, in those situations where one was hesitant about carrying out diodrast evaluation because of the presence of bilateral bronchial compression. It has also been helpful in patients in whom diodrast evaluation was forbidden, due to the presence of anginal symptoms or major bronchospastic tendency. Apparently a major principle being evolved in the application of planography to mediastinal tumors, is that the lesion will show its best definition if an air-containing organ, or organs, be seen on both sides of the lesions. If an air-containing organ is only on one side,

the proper definition of the tumor is usually obtained only on that side. A mediastinal tumor not in contact with any air-containing organ will not be discovered on planography unless it contains calcium or some other unusual density. In certain instances, where a lesion is in contact with the esophagus, an air balloon in the esophagus or a wide barium column may produce a satisfactory planographic study.

In summary, then, relative to planography, this is in the developmental phase but is becoming very impressive as to its value in regard to the study of mediastinal lesions.

**BIARIUM AS A CONTRAST MEDIUM:** We have laid considerable stress upon the importance of barium as a contrast medium in the study of the esophagus and upper gastro-intestinal tract. One must also mention the need for barium visualization of the large bowel in any mediastinal lesion having the potential of being a diaphragmatic hernia. Of course, if large bowel is present within the mediastinal space, the barium study of the large bowel will be completely diagnostic. It is also important to stress that diaphragmatic herniae containing no bowel, but containing omentum, will produce a distortion of the pattern of the transverse colon such that a barium enema will be completely diagnostic, even though barium does not appear within the confines of the mediastinal divisions.

**AIR CONTRAST MEDIA:** In order to separate the mediastinal and paramediastinal tissues, air may be used. Air has been utilized as a contrast medium in the study of mediastinal lesions for a longer period than any other contrast medium, with the exception of barium. It does have certain very definite objections. The first objection is the rare, but possible, danger of an air embolism when the air is used either in the pleural or peritoneal cavities. It is vital that anyone performing a pneumoperitoneum must be familiar with the important work of Durand relative to the use of the left lateral decubitus position whensoever a bolus of air in the main pulmonary artery occurs as a result of an air embolus in a systemic vein. This greatly reduces the risk from air contrast medium in the peritoneum, but no major safety measure is available relative to possible air embolus in pneumothorax. The second objection to air contrast medium is the possibility that a satisfactory space in either the peritoneum

or the pleural cavity cannot be obtained due to adhesions. Since the value of diodrast visualization of the right innominate vein and superior vena cava in the differential diagnosis of mediastinal and paramediastinal lesions on the right side has been understood, we find little or no need for a right pneumothorax in the study of tumors of the mediastinum.

The position of the left innominate vein is not so helpful, and, therefore, air contrast media in the left pleural cavity is occasionally necessary for superior mediastinal or paramediastinal lesions occurring on the left. Pneumoperitoneum is resorted to in patients who have had no previous peritoneal irritation from disease or operation when we cannot otherwise satisfactorily differentiate between an intradiaphragmatic and a subdiaphragmatic cause for the mediastinal mass. We have had opportunity to apply Durand's principle of treatment in systemic air embolus on four occasions in different departments at Emory University School of Medicine, and have found the procedure life-saving in all instances and feel that with this advance the risk involved in diagnostic pneumoperitoneum has become greatly reduced.

**INTRAVASCULAR DIODRAST AS A CONTRAST MEDIUM:** At this medical school intensive interest has been maintained in the study of venography and angiocardiology, by the utilization of diodrast. The value of angiocardiology and venography in the study of mediastinal and paramediastinal lesions, has been presented in detail, elsewhere. It is felt that it can be a very valuable adjunct in the study of these lesions. It is also felt that with proper evaluation of the physical status of a patient and the refusal to carry out diodrast studies in the presence of certain disease states, the risk involved in the procedure may be minimized, if not completely eradicated. We do not feel that this procedure should be carried out in any patient showing a major degree of bronchial obstruction, bronchospasm, angina, previous coronary occlusion, major decrease of renal function, or hypersensitivity to the drug involved.

Our experience with diodrast as a contrast medium in the study of mediastinal tumors has made us feel that there is a very definite and important place for the use of venography and angiocardiology, in the study of mediastinal and paramediastinal masses. We feel that the



angiocardigram provides the only certain method for differentiation between vascular and avascular lesions in the mediastinum. Angiocardiography has a definite but limited use in the investigation of non-vascular tumors of the mediastinum. In such a situation it can be helpful in better localization of the lesion and may aid toward the diagnosis, particularly if angiocardiography is used in conjunction with barium visualization of the esophagus.

By such a means we can rule out a vascular cause for a mass compressing the esophageal wall such as occurs in a leiomyoma lying at about the level of the left pulmonary artery. Certainly, angiocardiography is a frequent necessity in the study of many of the lesions arising in the middle mediastinum. It is of equal importance in lesions of the superior mediastinum, particularly in the right paramediastinal region, to such an extent that it has obviated the need for right pneumothorax contrast studies.

#### **Other Special Methods of X-Ray Investigation**

Our experience has not led us to believe that there is much value in the use either the roentgenkymogram or stereoscopic X-ray views in the study of mediastinal tumors. The roentgenkymogram appears mainly to be a photographic recording of one part of a fluoroscopic examination and is only necessary when one is uncertain of the findings seen at fluoroscopic examination. We have frequently obtained negative roentgenkymographic tracings in regard to the possibility of intrinsic source of pulsation in patients with aortic aneurysms. Equally false findings have occurred when the roentgenkymogram has suggested that the pulsation was intrinsic when it was actually transmitted. We have tried the P. A. stereoscopic view of the mediastinum on several occasions without much benefit. We have not as yet given stereoscopic X-ray views in the lateral projection a sufficient trial to define its value.

It will be noted that in the discussion of the diagnostic methods relative to mediastinal lesions, no mention is made in regard to so-called "diagnostic X-ray therapy." This omission is purposeful. We feel, strongly, that this practice has led to considerable faulty therapy and delay in instituting true remedial measures for the lesion involved. Furthermore, the policy that this method of attack is without

danger is considered to be false. We recently saw a patient who had been given "diagnostic X-ray therapy" for a mediastinal lesion. The primary lesion had been tuberculosis of the mediastinal lymph nodes, and the therapy given either produced, or was coincident with, a breakdown of the lymph nodes producing a fatal bilateral bronchogenic spread. We have frequently seen patients with aneurysms, either congenital or acquired, who have undergone repeated episodes of deep X-ray resulting only in some unnecessary pulmonary fibrosis. Frankly, it is our feeling that with a proper systematic diagnostic approach to the mediastinum, diagnostic X-ray will assume its proper position of being rarely, if ever, required. It is felt that with a satisfactory investigation one may not come to an absolutely accurate diagnosis, but one may formulate the proper type of treatment.

#### **Summary and Conclusions**

We have attempted to summarize the practical knowledge at present available relative to the diagnostic problem presented by tumors of the mediastinum. Marked improvement in the accuracy of the diagnosis of lesions occurring in this area, has occurred within the past two decades. It now appears that a wholly accurate diagnosis is not demanded in order to outline a proper plan of management of a mediastinal tumor. With a rational system of diagnostic approach a mediastinal tumor can be sufficiently evaluated that a reasonable therapeutic program may be outlined.

The basic factors involved in such an approach to the mediastinum consist, first, of a practical topographical classification of the mediastinum. Such a classification has been presented and is preferred because of its easy application to the lateral X-ray view of the mediastinum. Because of the existing tendency to suspect all mediastinal tumors of being lymph node in origin, emphasis has been placed upon the usual areas in which major lymph node concentrations appear. Attention has been drawn to the inconstant elements which may appear in the mediastinum, due to the fact that it is a mid-line structure and liable to present lesions resulting from faulty embryological development. The types and incidence of the lesions to be considered in the mediastinum have been discussed. Attention has been drawn to the most common lesion occurring in each of the medi-

astinal divisions. A discussion of the clinical significance of mediastinal tumors has been presented. From this, the conclusion has been drawn that any mediastinal tumor presents an inherent serious potential and, as such, has an important clinical significance.

The methods of diagnostic approach to mediastinal tumors have been discussed with particular reference to their practical usefulness and to their limitations. Mention has been made of the new interest being placed in symptoms produced by lesions which were formerly thought to be non-symptom producing. A plausible concept of the method of production of such symptoms via the intelligence of the autonomic nervous system has been suggested. The severe limitations at the present existent in relation to the physical diagnosis of the mediastinum have been considered and certain new practical aspects in this regard have been mentioned. The contention is made that, with increasing interest in the symptomatology and physical diagnosis of mediastinal tumors, these portions of the diagnostic approach will assume greater interest and greater value.

The laboratory methods of investigation have been briefly mentioned. Considerable attention has had to be placed upon the methods of X-ray investigation, as they assume the role of major importance in the diagnosis of mediastinal tumors as it is practiced in this day. Every mediastinal tumor must undergo adequate study by fluoroscopic examination, including barium swallow and postero-anterior lateral roentgenograms. The factors to be looked for in fluoroscopy of the mediastinum have been described.

Considerable attention has been paid to special methods of X-ray examination inclusive of laminagraphy and the use of different types of contrast media. The exact role of laminagraphy in the diagnosis of mediastinal tumors is not yet determined, but increasing experience suggests that this may be an extremely valu-

able procedure. Barium is considered the safest and most useful contrast medium which can be utilized. It is always necessary to visualize the esophagus. In some patients presenting lesions of the mediastinum in contiguity with the diaphragm, barium visualization of the large bowel is also required. The risks of air as a contrast medium have been mentioned. Attention has been drawn to the important work of Durand, in relation to the management of air embolism arising from systemic veins. The recent advances in the diodrast visualization of the right innominate vein and superior vena cava have practically obviated the need for air contrast medium in the right pleural cavity. Left pneumothorax may still be necessary in the differential diagnosis. The risks of pneumoperitoneum have been greatly decreased.

The role of intravascular diodrast as a contrast medium in the study of mediastinal and paramediastinal tumors has been briefly alluded to. A detailed description of the application of this method in relation to mediastinal tumors has been described elsewhere by the author. It is felt to be a very valuable adjunctive method in the diagnosis of these lesions. Its risk can be extremely minimized, if not eradicated, by proper consideration of certain restrictions existent relative to its use. The roentgenkymogram and stereoscopic X-ray views have not been found to be of major value in the study of mediastinal lesions in our experience. The use of so-called "diagnostic X-ray therapy" has been mentioned, mainly in order to condemn it. The attitude involved in the use of "diagnostic X-ray therapy" is felt to be an untenable attitude, in view of the present day rationale of the diagnostic approach to tumors of the mediastinum. It is felt that as greater experience is achieved and greater interest evolved in the problem of mediastinal tumors, there will be less need for "exploratory" thoracotomy, or "exploratory" X-ray therapy in the treatment of these lesions.

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**Pulmonary tuberculosis is the most serious public-health problem in the Philippines.** It exists throughout the islands in epidemic form, and it is estimated that 10 percent, or more, of the population suffer from it. The leading cause of death, it is one of the leading con-

tributors to the high infant mortality rate. The war not only increased all the predisposing factors, but destroyed most of the islands' means of coping with the disease. Leroy K. Young, M. D., Pub. Health Rep.



## HISTOPLASMOSIS

### With Brief Reference to Two Cases from Kentucky, One in a Dog

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Histoplasmosis was first seen by Samuel Darling,<sup>1</sup> a pathologist at Ancon in the Canal Zone, in 1905. In his own words he reported, "On December 7, 1905, while examining smears from lungs, spleen, and bone marrow in a case that appeared to be miliary tuberculosis of the lungs, I found enormous numbers of small bodies generally oval or round. Most of them were intracellular in alveolar epithelial cells, while others appeared to be free in the plasma of the spleen and rib marrow. Tubercle bacilli were absent."

His patient was a 27 year old Negro from Martinique, whose occupation was a carpenter and who had resided in the canal zone only three months.

In the next two years, Darling, quite by accident, found two more cases of this disease in his autopsy studies. His publications well describe and illustrate the tissue reactions due to this infection and the appearance of the organism within the tissue<sup>2,3</sup>.

#### Causative Organism

Darling thought the organism to be a protozoan, closely related to the flagellates, Leishmania. Major Leishman and Captain Donovan, of the British Army, had described the organism now known as *Leishmania donovani* a few years earlier in 1903<sup>5,6</sup>. Sir Donald Ross, the dean of English parasitologists, also regarded Darling's organism as a protozoan organism lending further weight to Darling's views and Darling named his organism as if it were a protozoa, *Histoplasma capsulatum*. Darling's studies showed the most frequently parasitized cell to be large mononuclear cells of the reticulo-endothelial system<sup>4</sup>.

For many years Darling's disease was considered a rare tropical disease. In 1912 Rocha-Lima<sup>7</sup> re-studied Darling's cases and came to the conclusion that the or-

ganism was a yeast-like fungus, rather than a protozoan. These observations have subsequently been confirmed.

The disease next appeared in an autopsy done in Austria in 1922<sup>8</sup>. However, little or no notice was taken of this publication by Americans as the case was published in a foreign language in medical literature not readily available. In 1926 Riley and Watson<sup>9,10</sup> discovered a case of histoplasmosis in an autopsy done in Minnesota. In 1932<sup>11,12,13</sup> when the organism was obtained by culture, Darling's organism could at last be studied in the laboratory, both from the cultural aspects and with experimental animals.

#### Prevalence

Since these early times the world-wide distribution of this disease is apparent from cases reported from Central America, South America, the United States, England, the Philippines, Java and South Africa<sup>14</sup>.

Numerous cases have been found over most of the United States, except New England, and it is apparent that the Mississippi Valley is quite an endemic area for this disease. Approximately one-third of the U. S. cases have been reported from Michigan, Missouri, Tennessee and Illinois. To my knowledge two cases have been reported from Kentucky,<sup>15,16</sup> although many cases have been diagnosed by physicians of this state.

Since this paper was presented Kotcher and Leikin have published seven cases of Histoplasmosis, six of which were from Kentucky. Kotcher, Emil and Leikin, Sanford: Histoplasmosis of Infants with a Report of Seven Cases. Jr. Ky. State Med. Assoc. 48:459 (Oct.) 1950.

At first it appeared that the disease was always fatal but with the advent of a skin testing reagent, Histoplasmin, it now appears that thousands of individuals have been infected and recovered from the infection, and the infection is fre-

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quently associated with hilar calcification just as is tuberculosis. Large numbers of Tuberculin negative individuals with hilar calcifications react positively to Histoplasmin<sup>17,18,19,20</sup>.

### Age Susceptibility

Individuals of all ages are susceptible to the infection, the youngest being reported was one month of age, and several cases in people past 70 are recorded<sup>14</sup>. Before the age of 10 years, both sexes are affected equally; but in the older age group, males contract clinical infections seven times as frequently as females. Such a sex distribution suggests a reservoir of infection outside the home where males are likely to contract the infection or be a passive carrier to little ones at home.

### Two Types

The disease appears to exist in two forms, a benign type of self-limiting pulmonary histoplasmosis which results in calcified hilar lymph nodes and possibly some degree of immunity, and a systemic infection in which the disease enters the body through the gastro-intestinal tract or other portals. Ulcerating lesions of the mucosal surfaces are a frequent finding in many of the reported cases. As the disease is disseminated by the blood stream, the reticuloendothelial system is stimulated to great proliferation. This accounts for the massive enlargement of the liver and spleen and generalized lymph-adenopathy. The organisms are actively phagocytosed by the R-E cells. Within the cell, further growth of organisms continues until the cytoplasm of the cell is filled with the yeast-like organisms and eventually the cell dies. This process produces granulomatous lesions with necrotic centers very similar to tuberculosis.

The blood stream carries the organism to the bone marrow which becomes invaded, producing marked destruction of blood forming tissue and resulting in anemia and leukopenia. Thus, I have briefly traced the pathological basis for the production of the usual signs and symptoms of the disease. Mucosal ulcerations, pneumonic miliary lesions, splenomegaly, hepatomegaly, lymphadenopathy, fever and leukopenia.

### Diagnosis

The diagnosis of the disease is not an easy matter as there are few non-specific

presumptive tests, the complement fixation and collodion agglutination tests of Saslaw and Campell<sup>21,22</sup> are probably of some value but as yet are not widely used. Diagnosis must be directed towards demonstrating the organism. As the organism has an intracellular habitat in the R-E cells, this, then is where the search is directed. The blood smear may yield a positive diagnosis, for the monocytes, the circulating member of the R-E system, may be carrying the organisms. This cell carrying the organisms may also be found in other material such as sputum and bronchial aspirations.

In biopsy specimens, large numbers of the intracellular yeast-like organisms are seen. Impressions of lymph nodes or ulcers stained with Wright's stain give diagnostic slides and do not require elaborate histo-technical methods of producing tissue sections. (Figure 1).

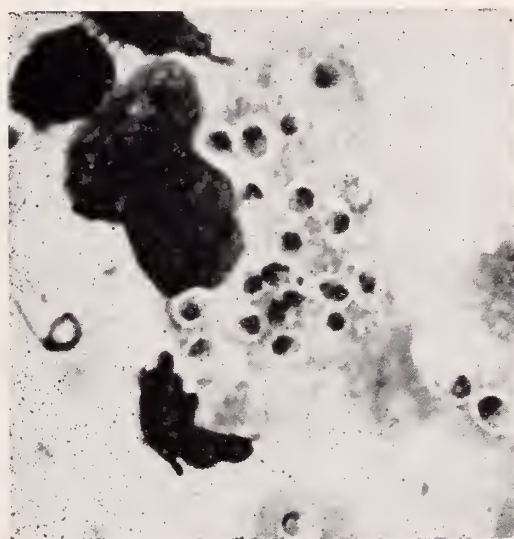


Figure 1

Histoplasma capsulatum in a Reticulo-endothelial cell as seen in an impression smear. Giemsa stain x440.

On culture the organism grows on most laboratory media. Its growth is slow, and cultures should be held a month or two for the development of diagnostic features. Culture tubes should be sealed to prevent drying out. On blood agar at 37° C. the yeast phase of the organism is produced, while on Sabouraud's fungus agar at room temperature the mycelial phase producing typical and diagnostic tuberculate chlamydospores is the type of growth seen. (Figure 2).



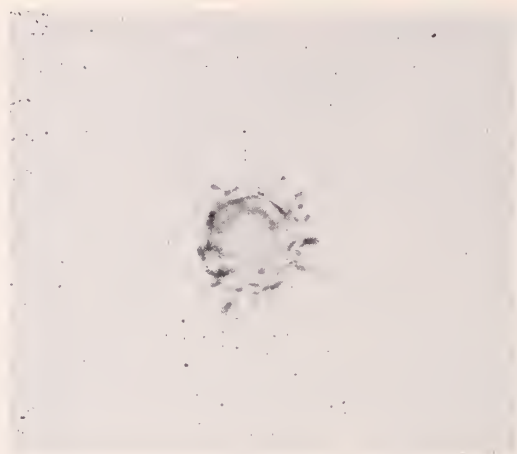


Figure 2

Tuberculate chlamydospore from a culture of *Histoplasma capsulatum* on Sabouraud's fungus agar at 20° C. Unstained preparation x440.

### Prevalence in Animals

Of considerable medical importance is the fact that large numbers of animals are susceptible to the infection<sup>14</sup>, dogs and rodents being the most common. These animals have a close association with man, and undoubtedly play a part in the dissemination of this disease<sup>23,24,25</sup>. A recent case I have studied was in a female Cocker Spaniel 18 months of age. This dog was born in a kennel in Louisville and was purchased by a Lexington physician as a pup. Thereafter this dog spent the remainder of its life in and about the home of the physician and had scarcely been off his premises. Had this physician had children in his home, I dread to think what the outcome might have been. However, there are no clear-cut recorded cases of transmission of histoplasmosis from animals to man. The dog apparently developed normally until two months before death, when she appeared not to be as lively as usual. After a few days, recovery was apparent and she remained well until a few days before death, when she lost her appetite and rapidly lost weight. Her breathing became very labored.

On examination the liver and spleen were found to be greatly enlarged and a mass was felt low in the abdomen. Also, fluid was thought to be present in the peritoneal cavity. The diagnosis of "Histoplasmosis" was made from a blood smear in which the typical organisms of *Histoplasma capsulatum* were found within the cytoplasm of numerous monocytes. At the time of this examination, the

hemoglobin was 39%; white blood count 32,200 per cubic mm., with 89% neutrophils; 25% lymphocytes and 9% monocytes; 3 nucleated red blood cells to 100 white cells were seen. Following this diagnosis, the dog was sacrificed and an autopsy performed.

### Autopsy Report

The autopsy revealed marked enlargement of the liver and the spleen and a large inflammatory mass in the mesentery near the ileocecal valve. Also, the retroperitoneal lymph nodes were greatly enlarged. From the blood stream and from the liver, cultures of *Histoplasma capsulatum* were obtained. Also, smears of the liver, spleen, lymph nodes and lungs revealed large numbers of *Histoplasma capsulatum*. Sections through the gastrointestinal tract showed large numbers of these cells containing organisms beneath the mucosa, and in the areas there were ulcerations of the mucosa; these cells being disseminated into the gastro-intestinal tract. This would indicate that a source of dissemination from animal to man would be through the intestinal tract of the animal with the contamination of the soil and surrounding habitat of that animal.

### Case Report in Infant

Recently a fatal case in a three month old white infant from Jessamine County, Kentucky, has been studied<sup>26</sup>. This infant was the fifteenth child of this mother to die before the age of three months.

Disseminated Histoplasmosis was diagnosed clinically before death and by a needle biopsy of the liver.

Autopsy revealed typical lesions throughout the viscera, and the organism was obtained by culture and studied mycologically.

### Summary

The literature of Histoplasmosis has been briefly reviewed and two cases of Histoplasmosis from Kentucky are presented, emphasizing the laboratory diagnosis of this disease by examination of blood smears, blood cultures, smears of tissue, liver biopsy, and tissue sections. Many of these methods are available to all physicians. The possibility of dissemination of Histoplasmosis from animal to man through contaminated soil and surroundings is suggested.

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## URINARY TRACT CALCULI

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Since the beginning of civilization, man has been subject to urinary tract calculi. Through the centuries, urinary calculus disease has taxed the ingenuity of the physician, provoked discussion, and stimulated research. Today it still remains one of the greatest problems of medicine.

Despite a great deal of research, the cause of urinary tract calculi is still unknown. Calculi result from the precipitation of salts which occur normally in the urine, but it is not known why this precipitation occurs. Kelly feels that "no stretch of the chemical or physiological imagination will permit so heterogeneous a group of compounds to be ascribed to a common origin or their deposition to an identical cause." Factors which may play a part in the etiology of urinary calculi are: colloid-crystalloid imbalance, stasis of urine, infection, vitamin A deficiency, endocrine disturbances, faulty calcium metabolism, race, and climate. It is probable that urinary stones result from the com-

bined action of several factors.

The manner in which calculi form is also unknown except in those cases of bladder stones which form about a foreign body. Infected urine may provide a nucleus of epithelium or bacteria upon which salts can deposit. In the absence of infection, the stone may form according to the theory of Hammarsten who postulates the formation of colloidal drops upon which crystalline deposits develop.

## Division Into Two Groups

Urinary calculi may be divided into two groups: (1) those which form in an alkaline urine (2) those which form in an acid urine. Phosphate and carbonate calculi develop in an alkaline urine. Oxalate, uric acid, cystine, and xanthine stones form in an acid urine. Pure stones are rare. Calcium oxalate is the most common constituent of urinary calculi being the predominant compound in one-third of all stones. Phosphates in combination with calcium, magnesium, and ammonium are next in frequency. Uric acid which



frequently forms the nucleus of a calculus, is the predominant constituent in only about ten per cent of the cases. Carbonate, cystine, xanthine, and urate stones are all rare.

Regardless of the etiology or the type of calculus, a urinary stone is a threat to the patient and will produce irreparable damage unless it is passed or removed. Until the underlying pathology of urinary tract calculi is understood, the problem consists primarily of diagnosis in order that the function of the kidneys can be preserved by proper and intelligent treatment. Although great advances have been made since 1896 when MacIntyre made the first X-ray diagnosis of renal calculus, the diagnosis of urinary stone is missed in 30-35% of the cases because the so-called classical symptoms are lacking, and the patient is treated for some non-existing condition.

### Symptoms

Pain is the most constant symptom of stone in the kidney and ureter, and is usually proportional to the degree of obstruction produced. Stones which obstruct the uretero-pelvic junction or the ureter produce sudden, severe, excruciating pain which may originate in the kidney area or along the course of the ureter. Radiation of the pain into the testicle or the labia is common. The patient is unable to remain quiet and moves constantly in search for some position which will afford relief. Such a patient is fortunate if the obstruction takes place before extensive renal drainage occurs because the patient demands prompt attention and because the diagnosis is seldom in doubt. Unfortunately the classical symptoms of renal colic are present in less than fifty per cent of the cases. In the remaining cases the pain may vary from a twinge or a dull ache to a moderately severe pain which is non-radiating. The location of the pain may be in the loin, the back, or the abdomen. Cecil reported a series of 300 cases of stones in the kidney or ureter in which twenty-eight per cent had abdominal pain without back pain. Not infrequently a stone may produce no pain and is called a "silent calculus." Such a stone may grow to great size in the kidney producing great destruction before a diagnosis is made. Calculi which are "silent" can usually be diagnosed by a careful consideration of other factors.

Gross or microscopic hematuria is probably present in all cases at some time.

Since hematuria always demands a complete urological investigation, calculi causing urinary tract bleeding should not be missed. It should be remembered that painless hematuria does not eliminate the possibility of a calculus.

### Pyuria

Infection, when present, will cause pyuria and may result in a secondary cystitis with frequency and dysuria. In fact, the symptoms in a case of silent stone may be only those of cystitis. With infection there may be chills, fever, and tenderness in the renal area characteristic of a pyelonephritis. Treatment directed toward the relief of the cystitis or the pyelitis may result in relief of the symptoms due to infection but will not affect the underlying cause, the calculus. All patients who have pyuria should be suspected of harboring a calculus, especially those in whom the pyuria persists or recurs despite adequate medical treatment. The diagnosis of cystitis or pyelitis is made too frequently without proper urological study.

### Gastro-Intestinal Symptoms

Reflex gastro-intestinal symptoms are frequent with renal and ureteral calculi. Abdominal pain, nausea, vomiting, rigidity, distention, leucocytosis, and fever occur with calculi. The symptoms may simulate diseases of the appendix, gall bladder, female adnexa, stomach, sigmoid, and pancreas. In thirty per cent of the cases, the predominant symptoms of upper urinary tract calculi will be abdominal rather than urinary. Thus twenty-five to thirty per cent of patients with calculi undergo surgery for non-existing abdominal pathology. The most commonly removed organs are the appendix, the female adnexa, and the gall bladder. Appendectomy is probably the most common operation for stone in the right ureter. At the Massachusetts General Hospital, O'Neil found that twenty-five per cent of the cases with ureteral calculi had had appendectomies without relief. Pain is referred frequently to the gall bladder as well as the appendix, but the gall bladder is somewhat more difficult to remove. It is impossible to estimate how many patients who have calculi are treated medically for non-existing cholecystitis and peptic ulcer. One must always remember how closely calculi can simulate abdominal pathology so that an accurate diagnosis will prevent unnecessary abdominal surgery which af-

fords no relief to the patient. All patients with indefinite abdominal complaints should have a urological investigation.

Renal calculi may also produce vague back pain and symptoms which lead to an erroneous diagnosis of lumbago, arthritis, sacro-iliac strain, disc, psychoneurosis and the like.

#### **Causes of False Diagnosis**

A negative urine at the time of examination of the patient probably accounts for many of the erroneous diagnoses. About twenty per cent of the patients with calculi will have no blood or pus in the urine when examined. It is wise to not accept a single negative urine when there is reason to suspect renal pathology. Repeated urinalyses should be done in such cases. If doubt still remains, further urological investigation should be carried out.

Stones in the urinary bladder are usually associated with obstruction of the vesical neck or urethra, with atony, tumor, or foreign bodies. The symptoms are those of a cystitis with frequent passage of small quantities of purulent urine. Pain is usually present in varying degrees of intensity and may be suprapubic, urethral, or perineal. The pain may be aggravated by shifting of the calculus due to body movement. Infection is always present and bleeding is common. In addition there are the symptoms of obstructive or neurological disorders of the bladder. Patients with vesical calculi are frequently treated with soundings, prostatic massage, instillations and the like. Those without symptoms of obstruction are not infrequently treated for long periods as cases of cystitis.

#### **X-Ray Diagnosis**

There are no typical symptoms of urinary tract calculi for even renal colic can be due to the passage of a blood clot or spasm. Thus the diagnosis must depend upon a proper evaluation of the history, the physical examination, and the laboratory findings so that further investigation of the urinary tract will be carried out. Probably ninety per cent of urinary calculi can be diagnosed by a simple KUB X-ray of the properly prepared patient. It is therefore appalling that thirty per cent of the cases with urinary tract calculi undergo useless surgery while an unknown number are treated medically for cystitis, pyelitis, or non-existing disease. A negative KUB X-ray, however, does not eliminate

the possibility of a calculus since eight per cent of stones are not opaque.

Whether the KUB X-ray is positive or negative for calculus, further investigation of the urinary tract will be necessary. An intravenous pyelogram is of great help in diagnosis for it localizes the stone and differentiates a calculus from phleboliths, calcified lymph glands, and other opacities. The intravenous urogram further provides some estimation of the renal function and the degree of obstruction.

Since the intravenous pyelogram may not give complete and adequate information on which to base treatment, cystoscopic examination is frequently necessary. By this means, the calculus can be definitely localized, differential renal function tests can be obtained, and the degree of obstruction can be determined. In addition specimens of renal urine can be obtained for microscopic study and culture and pH determination.

In addition to these examinations, blood chemistry determinations for calcium phosphorous, uric acid, and non-protein nitrogen should be made. It is probable that hyperparathyroidism occurs as a factor in the etiology of calculi more often than reported.

#### **Treatment**

The treatment of urinary calculi may be expectant, cystoscopic, or surgical. Expectant treatment is justified in those cases in which the calculus is small, that is less than 0.5 cm in diameter, in which the symptoms have been of short duration, in which there is no great deformity of the pyelogram, and in which no serious infection exists. Expectant treatment consists of forcing fluids, controlling pain, preventing infection if possible, and following the progress of the calculus by X-ray.

Calculi which do not satisfy the criteria for expectant treatment in the hope of spontaneous passage must be removed surgically or cystoscopically. It is not within the scope of this paper to discuss the surgical or cystoscopic treatment of calculi.

#### **Etiological Factors**

In addition to removal of the calculus, it is necessary to investigate all possible etiological factors and to correct them if possible. Thus stasis should be eliminated, infection controlled, etc. This is



especially true with vesical calculi which are usually associated with obstructive uropathy.

In conclusion, urinary tract calculi which are the end products of an unknown pathological process, will result in irreparable damage unless passed or removed. Conservation of the kidneys depends upon accurate diagnosis which can only be made by a proper evaluation of the patient and by a realization of the manifold signs and symptoms of urinary calculi.

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## OAK RIDGE GROUP CONTINUES STUDIES ON ISOTOPES

The ultimate result of splitting the atom is far from known at present. Scientists are attacking the problem from many directions. Some are striving for more powerful atomic bombs. Others are working on ways and means to prevent enemies from dropping bombs upon our cities. Civil defense officials are perfecting organizations to care for survivors in the event the enemy is able to penetrate our defenses and is successful in delivering his bombs.

In the midst of this frantic activity, both offensive and defensive, it is encouraging to know that the Medical Division of the Oak Ridge Institute of Nuclear Studies is continuing its effort to divert some of the products of nuclear physics to medical uses.

The first advanced course in the medical uses of isotopes to be offered by the Institute has recently been completed.

The course was given by five distinguished lecturers and by members of the Training and Medical Divisions. Over 40 physicians from 22 states attended the course.

Research studies are carried out on carefully selected patients who are referred by Medical Consultants. According to Dr. Gould A. Andrews, Chief Clinician of the Medical Division, the clinical program continues to emphasize Ga<sup>72</sup>. This metal shows preferential distribution in areas of bone formation or destruction. Dr. Andrews says that while the clinical results of treatment of primary and metastatic bone tumors have not been encouraging in most instances, a number of observations warrant further trials in primary osteogenic sarcoma and some additional types of bone tumors.

Intraperitoneal or intrapleural colloidal Au<sup>198</sup> has been used in the palliative treatment of intractable pleural effusion and ascites due to neoplasm. The results



suggest expansion of the study for more adequate evaluation.

The group is particularly desirous of admitting more patients with polycythemia, Hodgkin's disease, and chronic myelocytic leukemia.

Kentucky physicians who are interested in referring patients for treatment and study should contact Dr. A. J. Miller at the University of Louisville School of Medicine or the Louisville General Hospital for application blanks and further information.

The group of patients which the Medical Division is able to accept is as follows:

1. Metastatic carcinoma of the prostate with bone metastases of osteogenic type, in whom there is no further effect to be obtained by orchiectomy and hormone therapy.
2. Primary bone tumors with metastases.
3. Any type of primary or metastatic neoplasm in which bone involvement is present and is the main cause of symptoms. Patients should be in reasonably good general condition.
4. Pleural metastases from any type of carcinoma in which recurrent pleural effusion is the main problem, preferably without massive intrapulmonary lesions.
5. Carcinomatosis of the abdomen, without obstruction of the urinary or gastro-intestinal tract, in which ascite is the main cause of symptoms.
6. Carcinoma of the thyroid not amenable to surgical therapy.
7. Active Hodgkin's disease previously treated; patients for whom there is not satisfactory treatment, but who are not terminal.
8. Multiple myeloma.
9. Chronic myelocytic leukemia.
10. Polycythemia vera.

## PHYSICIAN PARTICIPATION IN BLUE SHIELD

Kentucky's Blue Shield Plan is making remarkable progress. Enrollment has reached 70,070. Its financial status is excellent. The entire sum of \$25,000 advanced by Kentucky State Medical Association has been repaid with interest. Means of broadening some benefits are being considered. Non-group enrollment is being studied from the standpoint of developing a contract that is actuarially sound which can be made available to individuals. This would give medical-surgical coverage to farmers and others who are not at present eligible since they are not members of an employed group.

Much of this progress has been accomplished in a relatively short time. The report of the Board of Directors to the House of Delegates in October showed 43,386 subscribers. At that time a majority of the doctors in only 44 counties had agreed to become participating physicians. Through the cooperation of physicians in 45 additional counties, the Plan is now available to the people of 89 counties. This is an increase of more than 100% in six months.

Participating physician agreement forms have been mailed to each physician in the remaining counties. Many doctors in these counties have already returned the signed agreements and in several

counties only one or two additional signatures are needed to give the required majority. At the time this is written only 89 additional signatures are lacking to permit the sale of Blue Shield contracts in all Kentucky counties. Since more than four weeks will transpire before this editorial will appear in print, it is likely that several additional counties will have been added to the list.

This fine cooperation by the profession is greatly appreciated by the Board of Directors of Kentucky Physicians Mutual, Inc., to whom the House of Delegates has entrusted the operation of the Plan. Since the Blue Shield Plan is the "Doctors' Plan" it could not exist without the cooperation of practicing physicians.

Availability of the Plan to the citizens of all counties has been the goal since the inception of the Plan. It is particularly important if non-group enrollment becomes a reality. It is well adapted to sale by newspaper advertising and it would be unfortunate to be in the position of having to list the counties in which it is not available. It is greatly to be hoped that the majority of physicians in all counties will have become participating physicians before the individual contract is developed.

The status as of April 5, 1951, is as follows:

**GREATER THAN 50% PHYSICIAN PARTICIPATION**

(Blue Shield Plan Available)

Adair	Greenup
Allen	Hardin
Anderson	Harlan
Ballard	Harrison
Bath	Henderson
Bell	Henry
Boyle	Hickman
Breckinridge	Hopkins
Bullitt	Jefferson
Butler	Johnson
Caldwell	Kenton
Calloway	Knott
Campbell	Knox
Carlisle	Larue
Carroll	Laurel
Casey	Lewis
Christian	Lincoln
Clark	Logan
Clay	Lyon
Clinton	McCracken
Crittenden	McCreary
Daviess	McLean
Elliott	Madison
Fayette	Marion
Franklin	Marshall
Fulton	Mason
Gallatin	Meade
Garrard	Menifee
Grant	Mercer
Graves	Metcalfe
Grayson	Monroe

Montgomery  
Muhlenberg  
Nelson  
Nicholas  
Ohio  
Oldham  
Owen  
Pendleton  
Perry  
Pulaski  
Robertson  
Rockcastle  
Rowan  
Scott

Shelby  
Spencer  
Taylor  
Todd  
Trigg  
Trimble  
Union  
Warren  
Washington  
Wayne  
Webster  
Whitley  
Woodford  
TOTAL 89

**LESS THAN 50% PHYSICIAN PARTICIPATION**

(Blue Shield Plan Not Available)

Barren	Jessamine
Boone	Lawrence
Bourbon	Lee
Bracken	Leslie
Breathitt	Letcher
Carter	Livingston
Cumberland	Magoffin
Edmonson	Martin
Estill	Morgan
Fleming	Owsley
Floyd	Pike
Green	Powell
Hancock	Russell
Hart	Simpson
Jackson	Wolfe
	*TOTAL 30

\*Boyd County is not included since it is served by the Ashland Plan.

## A COLLEAGUE PAYS TRIBUTE TO DR. A. M. LYON

As Chairman of the Advisory Committee on State Hospitals of the Kentucky State Medical Association and having recently accepted an appointment by Governor Wetherby to Chairman his Advisory Committee to the State institutions, I would like to take this opportunity to pay special tribute to Dr. A. M. Lyon, Superintendent of Central State Hospital, for his untiring efforts in behalf of the State Hospitals of Kentucky.

Dr. Lyon is a native Kentuckian and a graduate of the University of Louisville School of Medicine in 1912. After fourteen years in general practice he became Superintendent of the Kentucky State Training Home at Frankfort which post he held for ten years. Since that time he has held several positions in the State

service as Superintendent of Western State Hospital at Hopkinsville, then Central State Hospital, Director of Hospitals, and Commissioner of Welfare. Dr. Lyon has participated actively in the splendid rehabilitation program of our dilapidated State Hospitals over the past decade. His services were invaluable in the negotiations that resulted in the return of the Darnall Army Hospital at Danville to the State with approximately \$4,000,000 in improvements for which the State paid \$1.00. Within his memory there have been around \$15,000,000 spent on new buildings, rehabilitation of old buildings, and new acreage. At present there is a \$5,-500,000 building program for which contracts have been let for better housing for both patients and personnel. And so



today we are no longer ashamed of the living conditions in our State Hospitals.

Dr. Lyon worked particularly hard during the War years when personnel was hard to find and keep and doctors' services were almost impossible to obtain. I would like here to pay tribute also to the doctors, nurses and attendants who stayed on their jobs during the War and afterward, thus demonstrating their loyalty and devotion to the cause of care for the mentally sick in these institutions.

At each session Dr. Lyon has asked the Legislature for more money than he received for the proper maintenance of these institutions. In spite of that, progress has been made not only in better custodial care, but also in better medical and nursing coverage. It was not easy to change over to an eight-hour day, but this necessary and important improvement was accomplished several years ago. A good consulting program is under way at these hospitals. The Cancer Clinics have received special recognition nationally.

Dr. Lyon is justly proud of the building program and hopes that it will continue. He feels that if \$3,000,000 could be put into further rehabilitating these institutions during the next ten years, this would complete the over-all construction program for all institutions. This would include a new cottage system planned for the Kentucky Training School, a completely

equipped T. B. building at Central State to house all the t. b. mental patients in the State, and more adequate housing of the mentally sick aged.

What amazes Dr. Lyon's friends is that he has been able to spread himself over so many fields and so many miles and still keep going at his back-breaking pace. As Superintendent of Central State Hospital, he, however, will still have plenty to do. His knowledge of and experience in State affairs will be a great help to his successor in the office of Director of Hospitals in Frankfort one of whose main jobs will be to attract more and more physicians, nurses, psychiatric aids, social workers, psychologists and recreational workers into State service careers. It is hoped that these great institutions will eventually be approved by the A.M.A. as training hospitals for young psychiatrists as well as for other personnel so much needed if Kentucky is to supply its own personnel shortages. As every doctor knows, a good teaching hospital is a good treatment hospital.

We are all grateful to Dr. Lyon for his long years of service to the State and for the part he has played in helping to set the stage for the next steps forward toward a more ideal over-all treatment program for all the patients in our State Hospitals.

Spafford Ackerly, M. D.

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## :—: EDITORIAL COMMENTS :—:

**There has been a meeting of the minds** of the committees of the four major organizations dealing with hospital standardization. The details of agreement reached by the committees will not be announced until it has received approval by the organizations, which are the A.M.A., The American Hospital Association, The American College of Surgeons and the American College of Physicians.

It is most desirable that the new program, which may become effective about the end of this year, outlined by the committees ends the bickering concerning this important phase of medicine.

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**Medical textbooks are so rare in Thailand** that professors and students of the University of Bangkok are reproducing the precious few that they have by mimeographing them. In the absence of medi-

cal books, students are forced to rely solely upon lectures.

CARE is urging American men to alleviate this situation in Thailand and in 23 other countries in Europe and Asia by making cash contribution in any amount to CARE-UNESCO Book Fund, 29 Broad Street, New York City. For a donation of \$10.00 or more, donors may specify the kind of book, country, and specific institution they wish to help.

Medicine transcends national, race and ideological boundaries and many American physicians will wish to help these countries receive better trained physicians.

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**Work on a new technic for the early diagnosis of cancer** by cytologic examination of cells dislodged from the stomach is to be supported by a \$20,000 grant from

the Cancer Institute of the National Institute of Health.

Samples are obtained by washing the stomach with a solution of papain. The cells are examined by a technic similar to the Papanicolaou method. The workers have found 17 carcinomas of the stomach in 235 patients presenting various gastric symptoms. Some of the malignant lesions were too small to have been diagnosed by other methods.

The grant was made to continue the work of Doctors Herbert F. Traut and Milton Rosenthal in the University of California. Dr. Traut pioneered in developing the cytologic test in collaboration with Dr. George Papanicolaou.

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**The Army Medical Service now has 354** medical officers who have been certified as specialists by the various professional boards. According to the Army Surgeon General the number was only 127 in 1947.

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**A bill has been introduced in Congress** to permit refilling of prescriptions by pharmacists on verbal orders from the prescriber, if no habit-forming drugs are contained, provided the pharmacist reduces the order to writing within 72 hours. The bill would somewhat relax present restrictions concerning the refilling of prescriptions contained in The Food, Drug and Cosmetic Act.

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**Dr. George F. Lull introduced the subject** of A.M.A.'s Annual Meeting which will be held in Atlantic City, June 11-15, with the following "four-liner" which he called a "classic illiteracy":

Spring has come.  
The grass has riz  
I wonder where  
The flowers is.

Dr. Lull is anticipating a large attendance since Atlantic City Hotels have already processed more than 6,000 reservations.

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**There are few problems of community** health that cannot be solved by local initiative through cooperation of the citizens, medical societies and local health departments.

The Bureau of Health Education of A.M.A. has released a new transcribed radio series, "Main Street Medicine," re-

lating some of the health problems faced by communities and the solution which people all over the United States have worked out on the basis of their own needs.

"Main Street Medicine" consisting of thirteen transcribed fifteen-minute programs, with original music by Charles Paul, is available free of charge through state and local medical societies.

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**At the Sixth National Conference on** Rural Health at Memphis, Tennessee, sponsored by A.M.A.'s Committee on Rural Health, the Committee's Field Director, Aubry D. Gates, said that communities must accept the responsibilities of nutrition, environmental sanitation and immunization against infectious diseases if good health is to be attained. "Unless a community accepts these responsibilities, it will not have good health no matter how much and how good the medical care," he said.

All public health programs should lie in those fields of endeavor that require organized community effort for their effective performance.

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**In his capacity of Consultant to the Surgeon** General of the Air Forces, Dr. Elmer L. Henderson, Louisville, accompanied Maj. Gen. H. G. Armstrong and a group of medical personnel on an inspection trip of Air Forces Medical installations in Hawaii, Johnston Islands, Kwajalein Island, Guam, Philippine Islands, Okinawa, Japan, Korea and Alaska.

One of the primary purposes of the trip was to observe and evaluate air evacuation of wounded soldiers from Korean fronts to Tokyo hospitals and to hospitals in the United States. Dr. Henderson said, "The air evacuation operation of the 315th Air Division (Combat Cargo) is the greatest medical development of the entire Korean War." General Armstrong credited Combat Cargo with reducing the mortality from four and one-half per 100 injured men in World War II to two per 100 injured in the Korean campaign.

The group made the trip, which required three weeks, in an Air Force C-54 plane. While in Korea they observed 80 miles of the fighting front from the air. Returning from Korea to Tokyo was in a Combat Cargo plane which was filled with wounded soldiers.



# ORGANIZATION SECTION

## Scientific Exhibitors Urged To Apply For Space at Centennial Now

Members who wish to present a Scientific Exhibit at the Centennial Meeting in Louisville, October 2, 3 and 4, should reserve space for the exhibit before June 1, 1951, E. L. Pirkey, M. D., Chairman of the Committee on Scientific Exhibits, has announced.

It is urged that those desiring to participate write the Committee in care of the Headquarters Office, 620 South Third Street, Louisville, for application forms and any additional information needed. All applications must be completed and submitted before July 15, 1951.

"An unusually effective and profitable Scientific Exhibit is planned," Dr. Pirkey said. He indicated that the space for the exhibits in the Columbia Auditorium, site of the Centennial Session, would be ample and attractively arranged.

Dr. Pirkey has asked for a prompt response on the part of the participants in completing the forms so that the names of the exhibitors and a synopsis of their exhibit may be printed in the official program for the meeting.

## Three Societies Schedule Course on Atomic-Illness Treatment

Three county medical societies, in whose boundaries there are second and third class cities, have scheduled a special three-hour course in the treatment of casualties growing out of atomic warfare.

The Fayette County Medical Society will have the course on the evening of May 29, 1951, at Lexington; the Southwestern Kentucky Medical Association will have the course on the afternoon of May 8; and the Campbell-Kenton County Medical Society will entertain the instruction team at Covington, on Thursday, June 14, 1951.

The course, which was offered to the counties with second and third class cities, is jointly sponsored by the Committee on Emergency Medical Service of the Association and the University of Louisville School of Medicine, in cooperation with the State Civilian Defense organization. Arrangements for the course, which a number of the counties are now planning for, should be made through the Headquarters Office.

Pat R. Imes, M. D., Louisville, Chairman of the Committee on Emergency Medical Service, in urging counties in this population class to schedule the course, said, "Our patients have every right to expect the medical profession in Kentucky to be prepared not only to treat adequately A-bomb casualties in our own community but also to take care of patients who may be brought in from larger centers."

The Emergency Medical Service Committee and State Civilian Defense authorities urge that physicians in surrounding counties be invited to these courses. These agencies also urge the inviting of dentists in second and third class cities, as well as those in surrounding counties, to sit in on the courses.

Dr. Imes expressed appreciation for the cooperation of the many counties who had submitted the names of their local Emergency Medical Service Committees to the Headquarters Office, and reminded those counties who had not done so that his committee would be grateful for their consideration.

## Reunion Classes to Have Tables at Centennial Banquet

One of the highpoints of the Centennial Meeting will be the Reunion of the Classes of 1901, '11, '21, '31 and '41 of the University of Louisville School of Medicine.

Special tables will be reserved for each class at the Centennial Banquet as a result of arrangements made by Clark Bailey, M. D., Harlan, Chairman of the Committee on Arrangements, and Mr. Leslie Shively, Secretary of the University Alumni Association.

Members of these classes will be sent specific information in due time and every effort will be made to encourage full attendance.

## West Virginia Gets 4-Year Medical School

A four-year School of Medicine, Dentistry and Nursing has been established by the enactment of a law by the West Virginia State Legislature, thus ending successfully the campaign of several years effort of the West Virginia State Medical Association.

The law places the responsibility for the se-

lection of a site for the school solely on the Governor of the State, who has promised his decision before July 1, 1951.

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### **Kentucky Surgical Society to Meet at French Lick, Indiana**

Arthur W. Allen, M. D., Boston, Massachusetts, will be the guest speaker at the annual meeting of the Kentucky Surgical Society, Saturday, May 19, 1951, at French Lick Springs, Indiana. Francis M. Massie, M. D., Lexington, Secretary, Treasurer and Program Chairman, has announced.

In addition, the Society will hear four of its own members give scientific papers. Many of the surgeons are expected to bring their wives. The banquet will be held Saturday evening and will be followed by entertainment.

"Dr. Allen, a native of Somerset, Kentucky, and a graduate of Johns Hopkins Medical School, is a distinguished surgeon of international reputation," Dr. Massie said.

The Council of the Society will meet Friday evening. Pat R. Imes, M. D., Louisville, is president of the Society. Dr. Imes and Dr. Massie are ex-officio members of the Council. Council members are Charles A. Vance, M. D., Lexington, Chairman; E. W. Jackson, M. D., Paducah; and Malcolm Thompson, M. D., Louisville.

There are now fifty-four members and two senior members of the Society, whose membership is constitutionally limited to one hundred. "We expect to take in a number of applicants at the May meeting," the secretary said.

The program for the scientific session follows: "Carcinoma of the Thyroid," by Ernest C. Strode, M. D., Lexington; "Smith Peterson Nailing with Fibular Bone Grafts as a Primary Treatment for Fractures of the Neck of the Femur," by K. Armand Fischer, M. D., Louisville.

"Present Trends in Colon Surgery," by Arthur W. Allen, M. D., Boston, Massachusetts, with movies and lantern slides; "Surgery of the Esophagus and Cardia," by John S. Harter, M. D., J. Ray Bryant, M. D., and W. Burford Davis, M. D., all of Louisville; and "The Study of 1000 Consecutive Cases in a Private Office," by W. O. Johnson, M. D., Louisville.

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### **McGaff to Lead 150-Member U. of L. Medical Student Society**

Charles J. McGaff, Louisville, a sophomore, was elected President of the University of Louisville Society of Student A.M.A. at a re-

cent meeting of the new organization, when the local group adopted its constitution and by-laws.

The new organization, which has 150 paid members, elected William Ackerly, Louisville, a freshman, as Vice-President; Wanless Manville, a sophomore, as Treasurer; and Martha Harmon, Louisville, a sophomore, as Secretary.

The advisory committee for the local Student Society, as provided for under the Student A.M.A. constitution, has been appointed and is composed of the following: J. Murray Kinsman, M. D., Dean of the School of Medicine; two faculty advisors, Richard Taylor, M. D., pre-clinical years, and James C. Drye, M. D., clinical years; Austin Bloch, M. D., representing the Jefferson County Medical Society; and John S. Llewellyn, M. D., Louisville, representing the Kentucky State Medical Association.

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### **Emergency Call Service Established by Tri-County Society**

The Tri-County Medical Society, composed of Trimble, Carroll and Gallatin counties, has joined the growing list of medical societies in Kentucky that are providing emergency call service. H. V. Stewart, M. D., Carrollton, has announced.

The A.M.A. Board of Trustees recently urged all county medical societies to set up emergency call systems that would guarantee the people of the community the services of a physician at all times. The plan may vary with the size of the community, but, in the interest of the welfare of the people needing emergency medical service, some kind of rotation program is recommended.

A national survey in 1948 showed 60 of these plans in operation. In January, 1951, there were over 300. In spite of this increase, there are still many areas in which no program has been established.

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### **McCracken County to be Host to First District May 23, 1951**

The McCracken County Medical Society will be host to the physicians of the First Councillor District at Paducah, Wednesday, May 23, 1951, Councillor J. Vernon Pace has announced.

Sam A. Oversereet, M. D., Louisville, President; and Bruce Underwood, M. D., Louisville, Secretary and General Manager of the State Association, will bring the program.

W. P. Hall, M. D., Paducah, is President of the McCracken County group and George H. Widener, M. D., Paducah, is Secretary.



This will be the third meeting of the First Councilor District which is among the more active districts, for 1951.

### **Agricultural and Medical Leaders Discuss Rural Health**

The Committee on Rural Health met with Agricultural and Public Health leaders in the Headquarters Office on March 29, 1951, for the purpose of discussing methods of improving community health in rural areas.

The Chairman of the Committee, Walter L. O'Nan, M. D., Henderson, expressed himself as being well-pleased with the developments of the meeting, and announced that this same group, together with a few additions, would meet again in the near future.

Also attending the meeting was Mr. Aubrey Gates, Field Director of the Committee on Rural Health of the American Medical Association.

### **U. of L.-K.S.M.A. Seminar to be Held June 4 and 5, 1951**

The Medical Seminar of the School of Medicine of the University of Louisville and the K.S.M.A. will be held June 4-5, 1951, at the Kentucky Hotel in Louisville, Herbert L. Clay, M. D., Director of the Postgraduate Refresher Training Department of the School, has announced.

This course, which will be held in connection with graduation exercises at the Medical School, is open to all physicians in Kentucky and surrounding states. Eight credit hours will be given members of the Academy of General Practice attending the Seminar.

The sponsoring organizations, according to Dr. Clay, are: Jefferson County Medical Society; Kentucky Academy of General Practice; Kentucky Chapter of National Foundation for Infantile Paralysis; Kentucky Committee of Fractures and Other Trauma of the American College of Surgeons; Kentucky Division of the American Cancer Society; Louisville Regional Blood Center of the American Red Cross; and the Heart Association.

Program—Kentucky Hotel, Terrace Room,

#### **Monday, June 4**

- 9:00-10:00 Registration
- 10:00-10:15 Introduction and Orientation
- 10:15-12:00 Program by Cancer Society  
Gordon McNeer, M. D.—Carcinoma of the Stomach.  
Max Cutler, M. D.—Tumors of the Breast

R. L. Sanders, M. D.—Cancer of the Colon

- 2:00- 2:30 Thomas Gucker III, M. D.
- 2:30- 3:00 Kenneth G. Kohlstaedt, M. D.—The Use of Ion Exchange Resins in the Treatment of Edema
- 3:00- 3:30 Richard H. Chamberlain, M. D.—Clinical Uses of Radioisotopes
- 3:30- 3:40 Open
- 3:44- 4:10 Louis Krause, M. D.
- 4:10- 4:40 Max Michael, Jr., M. D.—The Effects of Cortisone on Certain Bacterial Infections

#### **Tuesday June 5**

- 9:00- 9:30 Russell Hayden, M. D.—Blood and Blood Substitutes
  - 9:30-10:00 J. Murray Kinsman, M. D.—Recent Advances in Cardiology
  - 10:00-10:30 Ralph G. Carothers, M. D.—Treatment of Colles Fractures.
  - 10:30-10:45 Open
  - 10:45-11:15 Walter S. Coe, M. D.—Congenital Heart Disease
  - 11:15-11:45 Thurman G. Blocker, M. D.—The Open Treatment of Burns
  - 11:45-12:15 Charles H. Kammelkamp, Jr., M. D.
  - 1:30- 2:30 Institute for Medical Research University of Louisville School of Medicine
  - 1:30- 2:30 Institute for Medical Research of the University of Louisville School of Medicine, located on the second floor of the Louisville General Hospital at 323 East Chestnut Street. There will be demonstrated various types of clinical, investigational procedures that are now being carried out in the Institute.
- All are urged to visit the Institute and see it in operation.

### **Pediatrics Course to Run Through June**

The Postgraduate Course in Pediatrics, which will be held at the Children's Hospital, in Louisville, will operate for nine consecutive Thursday mornings, starting May 3 and ending June 21.

In the April Journal programs for the May 3rd, 10th, 17th and 24th sessions are listed on Page 173.

The programs for the May 31st, June 7th, 14th and 21st periods are listed below. An invitation is extended to all Kentucky physicians to attend this course.

#### **Thursday, May 31**

- 9-10 Unusual Respiratory Infections in Children.....Elliott Podoll, M. D.

- 10-11 State Conference  
Leonard T. Davidson, M. D.  
Discussion by . . . . . E. Paul Scott, M. D.
- 11-12 Pediatric Thoracic Surgery  
John S. Harter, M. D.  
J. Ray Bryant, M. D.

**Thursday, June 7**

- 9-10 Problems in Poliomyelitis  
Alex J. Steigman, M. D.
- 10-11 Staff Conference . . . . .  
Leonard T. Davidson, M. D.  
Discussion by . . . Martin J. Harris, M. D.
- 11-12 White Blood Cell Dyscrasia  
Roxie T. Mudgett, M. D.

**Thursday, June 14**

- 9-10 Physiology of Fluids and Electrolytes  
William A. Brodsky, M. D.
- 10-11 Staff Conference  
Leonard T. Davidson, M. D.  
Discussion by . . Harry S. Andrews, M. D.
- 11-12 Treatment of Diarrhea  
Selby V. Love, M. D.

**Thursday, June 21**

- 9-10 Cancer in Childhood  
Roxie T. Mudgett, M. D.
- 10-11 Staff Conference  
Leonard T. Davidson, M. D.  
Discussion by  
Walter A. Kirchner, M. D.
- 11-12 Celiac Syndrome  
Nathan I. Handelman, M. D.

## Second District Meeting Attracts 85 at Owensboro March 29

Approximately eighty-five physicians of the Second Councilor District, and their wives, attended the District Annual Meeting at Owensboro, March 29, which was described by R. Haynes Barr, M. D., Councilor, as perhaps the largest and best session held by the district.

Ephraim Roseman, M. D., Louisville, Professor of Neurology at the University of Louisville School of Medicine, presented a scientific paper entitled, "Epilepsy." Sam A. Overstreet, M. D., Louisville, President, brought greetings from the State Association; and Bruce Underwood, M. D., Louisville, Secretary and General Manager, brought greetings from the Headquarters Office.

Mrs. John D. Harter, Louisville, President-Elect of the Woman's Auxiliary to the State Medical Association, spoke briefly, as did Mrs. John S. Oldham, Councilor for the Auxiliary for the Second District. Before the scientific session, the wives of the physicians moved to another room for their own meeting.

F. Hays Threlkel, M. D., Owensboro, succeeded Walter L. O'Nan, M. D., Henderson, as

President of the Second Councilor District Medical Association; O. T. Davis, M. D., Owensboro, succeeded Robert W. Smith, M. D., Owensboro, as Secretary of the Association, in an election of officers at the meeting.

**K.S.M.A. Lists New Members**

Following is a list of new members which the K.S.M.A. welcomes into the Association:

Samuel M. Smith, Jr., M. D., Louisville; J. Steigman, M. D., Louisville; William C. Durham, M. D., Louisville; Albert E. Smith, M. D., Louisville; Spaulding Abell, M. D., Louisville; Jack Dick, M. D., Louisville; C. E. Crabtree, M. D., Buffalo; W. B. Wallin, M. D., Brooksville; Martha A. Loving, M. D., Lackey; F. S. Trover, M. D., Madisonville; Thomas R. Havens, M. D., Louisville; Melvin Shein, M. D., Louisville; Arthur H. Keeney, M. D., Philadelphia, Pa.; Robert L. Shuffitt, M. D., Greensburg; R. J. Phillips, M. D., Owenton; and John Futrell, M. D., Cadiz.

**C. E. Reddick, M. D., Is Named Deputy Health Commissioner**

The State Department of Health has announced the appointment of C. E. Reddick, M. D., formerly of Kentucky, as Director of Local Health Services and Deputy Health Commissioner, effective April 16, 1951.

Dr. Reddick returns to Kentucky from Phoenix, Arizona, where he has been Director of Local Health Commission and State Health Officer. Before leaving Kentucky, he was Assistant Health Officer of McCracken County from November, 1937 to October, 1940. He then served as Health Officer of McCracken County from November, 1940 until July, 1946.

**Freedoms Awards Given Dr. Henderson**

Two awards by the Freedoms Foundation, given for outstanding contributions to Freedom during 1950, have been presented to Elmer L. Henderson, M. D., Louisville, president of the A.M.A. Education Foundation.

His speech, "Medical Progress vs. Political Medicine," delivered over a nation-wide radio hook-up from the A.M.A. Annual Meeting in San Francisco last June, won an award of \$100 for fourth place. The Certificate of Merit award was presented him for his article, "Here's Health—the Voluntary Way," which was published in the May, 1950 issue of the Readers Digest.

Dr. Henderson was among 800 persons and organizations who participated in the Freedom Foundation's \$100,000.00 awards.



### Proctologic Society Meets at Louisville

Henry B. Asman, M. D., Louisville, was succeeded as president of the Ohio Valley Proctologic Society by Robert E. Pumphrey, M. D., Dayton, Ohio, at the Society's Annual Meeting in Cincinnati on March 9, 1951.

One of the guest speakers at the next meeting of the Society will be George B. Sanders, M. D., Louisville. The meeting will be held at Big Spring Golf Club, Louisville, on May 11, 1951.

### K.S.M.A.-K.S.D.A. Committee Named

The appointment of a K.S.M.A. Dental Committee has been announced by Sam A. Overstreet, M. D., Louisville, president of the Association, to serve with a similar committee from the Kentucky State Dental Association for the purpose of considering matters of mutual interest to the two professions.

Members of the new Committee are John J. Wolfe, M. D., Louisville, Chairman; Thomas J. Crume, M. D., Owensboro; and Allen L. Cornish, M. D., Lexington.

Morris Wilson, D. D. S., President of the K.S.D.A. has appointed the following to represent his Association: Albert P. Williams, D. D. S., Chairman; Joseph L. Seldon, D. D. S.; and Elmer C. Hume, D. D. S., all of Louisville.

### General Practice Award

The Academy of General Practice of Kentucky is offering an award for the best paper submitted on any subject pertaining to general practice. Dr. D. G. Miller, Jr., Morgantown, Kentucky, Secretary-Treasurer of the Kentucky Academy of General Practice, has supplied the rules governing the award as follows:

1. Any general practitioner in Kentucky may submit a paper based on original work he has done as a general practitioner.
2. Paper to be typewritten, double spaced, on one side of plain white paper, bearing no name, sealed envelope to be clipped to paper containing name and address of physician submitting the paper.
3. Paper must be submitted before July. Send to Academy office in Morgantown, Kentucky.
4. May be on any subject the writer wishes.
5. Will be judged by three University of Cincinnati physicians.
6. Award will be based on originality and practicability of research.

## Pertinent Paragraphs

**Alpha Omega Alpha, Honorary Medical Society**, will present Carl J. Wiggers, M. D., Western Reserve Medical School Physiology Professor, who will discuss "Regulations of Cardiac Performance—Facts vs. Theories." This lecture, open to the public, will be held in the Amphitheater at Louisville General Hospital at 4:00 p.m., May 18, 1951 and is a part of the Annual Meeting of the Society. Following the lecture there will be a banquet at 6:30 p.m. at the Seelbach Hotel and initiation services.

**Two Louisville physicians, Guy Aud, M. D.** and John D. Trawick, M. D., participated in the program of the Symposium on Malignant Diseases, at the Indiana University School of Medicine, April 3 and 4. Doctor Aud is clinical professor of Surgery at the University of Louisville School of Medicine and is President of the American Cancer Society. Doctor Trawick, who is assistant professor of Psychiatry at the U. of L. School of Medicine, participated in the Indiana State Medical Association Roundtable Telephone Discussion on April 3.

**The Kentucky State Department of Health** has announced the appointment of Mr. Fred A. Miller as Director of Public Health Laboratories, according to Bruce Underwood, M. D., State Commissioner of Health, who expressed his appreciation of the good work done by Mr. Miller over a period of years. Lillian H. South, M. D., Louisville, will continue as Director of the School of Laboratory Technique.

**Russell E. Teague, M. D., formerly of Kentucky**, has been appointed State Secretary of Health in Pennsylvania. Dr. Teague has had twenty years of Public Health experience, including the holding of such positions as Health Officer of Wayne, Pike and McCracken Counties in Kentucky, and, from 1942 to 1945, he was Assistant Commissioner of the Kentucky State Department of Health.

"What You Should Know About Biological Warfare" is the title of a booklet issued by the Civil Defense Administration. It emphasizes the importance of the cooperation of the medical profession and the public in combating any type of "BW" which might be encountered. Although the pamphlet is not for national distribution, a limited number of copies are being furnished to state civil defense organizations and the press, so that the public will, through reprints, become acquainted with its contents.

The new Medical School of the University of California at Los Angeles is to open with class next September 19. The first class applications for 25 students for first-year medical study will soon be accepted. All applications should be filed by May 15. Information about the School and the courses offered may be obtained from U. C. L. A.'s Office of Admissions, 405 Hilgard Ave., Los Angeles 24.

The seventh Annual National Conference on Rural Health will be held February 28, 29 and March 1, 1952, in Denver, Colorado, in the Shirley-Savoy Hotel, according to F. S. Crockett, M. D., of Lafayette, Ind., chairman of the A.M.A. Committee on Rural Health.

The "Grass Roots" meeting of the National Conference of County Medical Society Officers, scheduled during the A.M.A. meeting in June at Atlantic City, will not be held. It was postponed because of the illness of the Chairman, A. M. Mitchell, M. D., Terre Haute, Indiana, a graduate of 1913 from the University of Louisville School of Medicine. Dr. Mitchell said all the doctors who would have attended the meeting should plan to go to the Conference of Presidents and other Officers of State Medical Associations on June 10, at the Hotel Traymore, Atlantic City.

Physicians' wives should join a Woman's Auxiliary because they can, as a group, further the aims of the medical profession by keeping them informed and informing others, by cooperating with the health programs of their communities, and by advancing progressive health legislation and opposing that which is dangerous to the welfare of the people. These reasons were given by Ed Bridges, Director of Public Service of the Tennessee State Medical Association, in the Association's Journal.

The American Physicians Art Association will have an exhibit during the American Medical Association Convention at Atlantic City, June 11-15, 1951. There will be 200 trophies awarded in addition to the special Helser trophy for art work done in any medium. The Annual Art Banquet will be held June 12 at the Marlborough-Blenheim Hotel, Atlantic City.

The University of Cincinnati and the Kettering Laboratory of Applied Physiology, Cincinnati, have cooperated in offering a hospital course in physical medicine and rehabilitation, as a means of reducing the number of man-hours lost in industry. Because of the nationally recognized importance of physical medicine and rehabilitation in industry during the past several years, the course was offered.

## KENTUCKY PROCUREMENT COMMITTEE NEWS

by

A. Clayton McCarty, M. D., Chairman

### Counties Urged to Survey Medical Manpower Needs

Several counties have made a survey of their medical manpower resources and have submitted the results of the survey to the Kentucky Procurement Committee.

Our Committee welcomes this interest and information from these counties and urges other counties to conduct such an effort and send the information to the Committee.

Furthermore, if county societies have appointed committees to advise on Procurement matters (or expect to do so in the near future) the names of such appointees, with indicated chairmen, should be reported to the Headquarters Office as soon as possible.

Please direct your correspondence to the Kentucky Procurement Committee, 620 South Third Street, Louisville.

### Deadline for Military Services Transfer Is Near

Officers of the military medical services who wish to apply for transfer from one military service to another have only until July 9, 1951 to do so, the Department of Defense has announced.

The Medical Corps, Dental Corps, Nurse Corps, Medical Service Corps, Veterinary Corps, and Women's Medical Specialist Corps are the services affected by the transfer privilege authorized by Public Law 779. Retired officers and commissioned warrant officers of the Navy's Hospital Corps are not eligible for transfer, as there is no comparable grade in the Army.

Those transferring will retain the Federal service already performed for use in promo-



tion, seniority and retirement. There is no loss of unused leave with the transfer.

### **Military Intern Program Announced**

Major General R. W. Bliss, Army Surgeon General, has announced the appointment of 132 senior medical students for the military intern program of the Army Medical Service.

This program allows medical students, upon graduation, to obtain the commission of a first lieutenant in the Medical Corps Reserve and serve their internship in an Army hospital. There is a new requirement for the first time since World War II which decrees that the new doctors serve one year on active duty in addition to a year of internship.

### **July 1 Is Important Date**

This is an important date for Priorities I and II. Selective Service has stated repeatedly that men in the first two priorities, not in service, disqualified or in a reserve, will be **INDUCTED** on July 1, 1951.

### **Priority Classification of "Doctor Draft Act" Described**

Due to the lack of understanding of the priority system set up under Public Law 779 81st Congress by many of the physicians of the State, the Procurement Committee is presenting the wording of the Act covering the four priorities.

It should be noted that the law—sometimes called the "Doctor Draft Act"—specifically describes the four priorities. It also states that eligible men in priority I will be exhausted before any are called from priority II, priority II before priority III, etc., in the order listed.

Public Law 779 81st Congress amends the Selective Service Act of 1948 to require the registration of male persons in needed medical, dental and allied professions who have not reached the age of 50 and who are not members of a reserve component of the armed forces.

"The priorities for registration and induction are defined in the law as follows:

"First. Those persons who participated as students in the Army specialized training program or similar programs administered by the Navy, and those persons who were deferred from service during World War II for the purpose of pursuing a course of instruction leading to education in one of the categories re-

ferred to, who have had less than ninety days of active duty in the Army, the Air Force, the Navy, the Marine Corps, the Coast Guard, or the Public Health Service subsequent to the completion of or release from the program or course of instruction (exclusive of the time spent in postgraduate training).

"Second. Those persons who participated as students in the Army specialized training program or similar programs administered by the Navy, and those persons who were deferred from service from World War II for the purpose of pursuing a course of instruction leading to education in one of the above categories, who have had ninety days or more but less than twenty-one months of active duty in the Army, the Air Force, the Navy, the Marine Corps, the Coast Guard, or the Public Health Service subsequent to the completion of or release from the program of course of instruction (exclusive of the time spent in postgraduate training).

"Third. Those who did not have active service in the Army, the Air Force, the Navy, the Marine Corps, the Coast Guard or the Public Health Service subsequent to September 16, 1940.

"Fourth. Those not included in the first and second priority who have had active service in the Army, the Air Force, the Navy, the Marine Corps, the Coast Guard, or the Public Health Service subsequent to September 16, 1940. Inductions of persons in this priority shall be made in accordance with regulations prescribed by the President which may provide for the classification of such persons into groups according to the number of full months of such service which they have had and for the induction of the members of such group after the induction of the members of any other such group having a lesser number of full months of such service."

The President issued a proclamation calling for the registration on October 16, 1950, of physicians, dentists, and veterinarians in the first two priority groups. Registration for the third and fourth priority groups was carried out January 16, 1951.

Much confusion exists concerning the meaning of the above-mentioned words commonly used in connection with medical Selective Service matters. Priority has been well illustrated in the above article; Category is a term used to describe the profession being discussed — physicians, veterinarians, dentists, etc. Classification means the "pigeonhole" into which one is placed by the Draft Board before or after examination, as I-A, 4-F, etc.

# President's Page

No man liveth unto himself. In our present complex society every year emphasizes more and more the interdependence of individuals and groups. Perhaps the medical profession has tended to stand aloof in years past in a smug sort of security. At least we have been so informed. Personally, I would not know. During the period of my acquaintance with it this has not been true. Doctors have generally shown themselves active, interested, participating citizens of the community, increasingly aware of their limitations and alert to their responsibilities for the general health. In no profession is a larger amount of time and money spent per capita in postgraduate study or on current literature each year in order to improve the intellectual armamentarium and keep abreast the rapid advances of modern research.

The present trend toward specialization is not wholly a selfish impulse of individuals to provide themselves a better professional status or a more leisurely and remunerative practice. There is a genuine desire to know more thoroughly the nature of a specific type or group of diseases and to provide skills and remedial measures not known to the preceding generation or decade. And the net result is better health and longer life for the American people. At an increased cost? Yes. But almost all improvements in our life today are at an increased cost and it cannot be otherwise.

But the medical profession cannot move forward alone. Improvement in nursing, in hospitalization, in pharmacy, in veterinary practice, are so intimately a part of our better health that we must share with these, our allied professions, a tremendous portion of the credit for our advances.

Good nursing is the sine qua non of successful care of the sick. Facilities provided in our hospital structure and equipment save quite as many lives as do our surgical skill and therapeutic resourcefulness. The researches carried on by our pharmaceutical houses and the information placed by them at our disposal are beyond the imagination of the previous generation of physicians. Control of milk and animal-borne disease is the accomplishment of veterinary medicine quite as much as our own.

These professions and others less intimately concerned with our daily battle against disease, disability, and death are our indispensable allies. Knowing that they will stand or fall with us in our efforts against regimentation they have contributed largely of funds and moral support in our recent campaigns. They have awakened to our common peril and will stand with us henceforth.

The dental profession is so closely allied with medicine that we must consider our field as one. It is in fact really a medical specialty only so divided that specialized training in this branch begins five years earlier than in surgery, orthopedics, or obstetrics. So we speak of the dentists differently than the above mentioned allied groups.

Closest liaison and cooperation of all these professions concerned with health is more important now than ever before. To facilitate this, committees have been formed to work with similar committees from them in such common problems as may be ours. Let us learn better to work together—to pool our resources and interests—to serve together the people of our communities and the state at large. United let us stand.

*Sam A. Overstreet*

PRESIDENT



# County Society Reports

## BOYLE

The Boyle County Medical Society met in the dining room of the Ephraim McDowell Memorial Hospital at 7:30 p.m., February 15, 1951 with the following members present: Drs. A. M. Jester, President; W. H. Smith, O. L. May, J. Rice Cowan, W. O. Hopper, J. L. Clay, H. L. Gragg, A. H. Walker, S. P. Hemphill, Milton Davis, and E. M. Montgomery; and guest Dr. Emil Kotcher, from the Kentucky State Department of Health, Louisville. After a business session at which the minutes of the last meeting were read and approved, Dr. E. M. Montgomery presented the idea of fluorinization of the Danville city water supply. Dr. Montgomery quoted statistics to show that increasing the fluorine content of the drinking water greatly reduced the percentage of dental caries in the area, and since the cost of the program would amount to less than ten cents per water user per year, he felt that it was a rather worthwhile undertaking, and after some general discussion a motion was made by Dr. Montgomery that the County Society go on record as approving in principle fluorinization of the Danville city water supply. This motion was seconded by Dr. A. M. Jester and unanimously carried.

A plea was made by the secretary for the few remaining delinquent A.M.A. membership dues, and it was announced that all of the State and County dues had been paid in full for this year with the exception of two dentist members.

Dr. Emil Kotcher, Epidemiological Consultant, from the Kentucky State Department of Health, then gave a talk emphasizing the importance of statistical reporting by the local physician and making a plea that reportable diseases get reported to the County Health Officer and thereby get transmitted to the state statistical organization. He pointed out that his organization was anxious to help in identification of any disease or epidemic entities and told of coming to this county in the past year on two occasions for help with a case of smallpox and botulinus poisoning. Epidemiology of various diseases as presently understood was discussed including polio, influenza, epidemic pleurodynia, and the common bacteriological infectious diseases. In the period of questions and answers, quarantine of scarlet fever was discussed and the Society agreed to the present State ruling that with the use of antibiotics scarlet fever was no longer a quarantinable disease. The need for early and repeated vaccination of children

against diphtheria was stressed since diphtheria is such a rare disease now that the ordinary subclinical diphtheria infections which normally would give booster antigen to the older children does not seem to be present so that children in the teen ages and even young adults are getting clinical diphtheria now. Also it was noted that mothers are having babies without the mothers themselves ever developing any immunity to diphtheria which would naturally not give the baby the theoretical first three to six months of immunity to diphtheria, making early vaccination quite imperative.

There being no further business the meeting was adjourned at 9:30 p.m.

Charles W. Caldwell, Jr., Secretary

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## FOUR COUNTY MEDICO-DENTAL

The Four County Medico-Dental Medical Society met in Princeton, Friday, February 23, 1951.

The following officers were elected for 1951: Drs. M. H. Moseley, Eddyville, President, succeeding W. L. Cash, Princeton; W. F. Stucky, Dawson Springs, Vice-President, succeeding John E. Haynes, and H. B. Sandlin, Cadiz, re-elected Secretary. Dr. Frank T. Linton, Princeton, read a paper on "The Aging Heart," and Dr. W. Duane Jones, Madisonville, discussed "General Policies and Report of Activities of District One, State Tuberculosis Hospital."

The next meeting of the society will be held on the fourth Friday night in May in Marion, Crittenden County.

W. L. Cash, Retiring President

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## JEFFERSON

The February meeting of the Jefferson County Medical Society was held on Monday evening, February 19, 1951, at the Seelbach Hotel. Eighty-seven members and guests were present for dinner, and twenty additional for the business and scientific sessions.

The meeting was called to order by the President, Dr. Lytle Atherton, at 8:00 o'clock p.m. The minutes of the previous meeting were read and approved.

Dr. J. Andrew Bowen read the report of the Executive Committee recommending that Miss Walker receive the usual bonus for the year 1950, and that her salary for the year 1951 be raised so as to obviate a bonus at the end of the year 1951.

The Executive Committee also recommended

that an additional one dollar per active member be allotted to the medical library from the funds of the Society at the end of the year 1950, making a total of \$3.00 per active member. Motion by Dr. E. Lee Heflin that the recommendation of the Executive Committee concerning Miss Walker's salary for 1951 be accepted. Seconded and carried.

Motion by Dr. Robertson O. Joplin that Miss Walker receive the usual bonus for 1950. Seconded and carried.

Motion by Dr. Harry Goldberg that the recommendation of the Executive Committee with reference to additional funds for the medical library, be accepted. Motion seconded and carried.

Dr. A. Clayton McCarty, Chairman of the State Civilian Defense Committee, made a preliminary report on the plans for organization, and urged members of the Society to serve with the group, if requested. A more detailed report will be made at the next meeting.

The following applications for Emeritus Membership were approved: Drs. I. A. Arnold, Charles O. Neff and Griffin C. Kelly. The following were elected to Active Membership: Drs. John D. Allen, Jr., Francis J. Smith, and Samuel M. Smith. To Associate Membership: Drs. William C. Durham, Charles E. Pearce, and Irvin H. Sonne, Jr.

The Secretary read a letter from Dr. Herbert L. Clay, Director, Post-Graduate Refresher Training, University of Louisville School of Medicine, regarding plans for a Medical Seminar June 4, and 5, 1951, and requesting that the Society again sponsor two speakers at this seminar.

Dr. Charles F. Wood moved that the Society sponsor two speakers. Dr. R. O. Joplin raised a question as to how the speakers are selected. This was answered by Dr. Lytle Atherton and Dr. H. L. Clay. Dr. R. O. Joplin made a motion that the President appoint a committee of three to meet with the Seminar Committee. Seconded and carried. Dr. Lytle Atherton suggested that the Program Committee might serve in this capacity.

The Secretary read a communication from Mr. J. G. Hawkins, Physical Therapist, enclosing copy of a proposed letter to be sent to members of the Society. Motion by Dr. Houston Shaw that this matter be referred to the Professional Relations Committee for action, and that a report be made at the next meeting. Motion seconded and carried.

The Secretary read a notice from Mr. J. P. Sanford, Kentucky State Medical Association, stating that the County and State dues are \$25.00 per year (State \$15.00 and County \$10.00). American Medical Association dues are

\$25.00 per year, making a total of \$50.00 dues per year.

The Scientific program followed with a symposium on the Essentials of Diagnosis and Primary Treatment of the Injured, by the Kentucky Regional Committee on Trauma, with Dr. Charles F. Wood acting as moderator.

1. "General Principles of Diagnosis, and Primary Treatment of the Patient," Charles H. Maguire, M. D.

2. "Treatment of Hand Injuries," George B. Sanders, M. D.

3. "Treatment of Burns," Roy H. Moore, Jr., M. D.

4. "Treatment of Fractures," Morgan R. Colbert, M. D. and Discussions by Drs. R. Arnold Griswold, John J. Wolfe, Joseph D. Heitger.

The meeting adjourned at 9:35 p.m.

Austin Bloch, Secretary

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### LETCHER

The regular monthly meeting of the Letcher County Medical and Dental Society was held Tuesday night, February 27th, 1951 in the Whitesburg City Hall. The following members were present: Drs. Lundy Adams, President, A. B. Carter, E. G. Skaggs, Steve H. Bowen, Lee Moore, B. C. Bach, Carl Pigman, Owen Pigman, Billy M. Adams, R. Dow Collins.

The meeting was called to order by the President, Dr. Lundy Adams, and minutes of the previous meeting were read and approved. The Secretary read many letters pertaining to the society's business and these were discussed. After Dr. B. C. Bach's discussion, the society members agreed to examine the Boy Scouts for their annual encampments, all free of charge.

Since we have a few physicians and dentists who failed to align themselves with our society for 1950, it was agreed to especially invite the following into the 'fold' for 1951; Dr. J. E. Crawford, Whitesburg, Dr. J. J. Croley, Jenkins; Dr. J. E. Skaggs, Neon; Dr. Sam Quillen, Neon; Dr. T. D. Vaughn, Jenkins. These physicians and dentists will be urged to join the memberships. Furthermore, several have not paid their 1951 dues who were members in 1950, but we are sure these will soon pay.

Dr. Billy M. Adams, read a brilliant dissertation on "Bronchial Asthma" and other allied Allergic disorders; practically every member present added to this informative paper; we all were pleasantly surprised that our Dr. Adams had garnered so much deep insight to problems of the Asthmatic and could elucidate so clearly and forcefully on this important disease.

Dr. E. G. Skaggs asked us to bear in mind



that he had an accredited laboratory at the Fleming Hospital and was now ready to do laboratory analyses for the public; fees are comparable to the usual laboratory costs. Dr. Skaggs treated the society to refreshments, for which we are grateful.

There being no further business the meeting adjourned at 10:30 p.m. The next meeting is to be Tuesday night, March 27, 1951.

R. Dow Collins, Secretary

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### LETCHER

The regular monthly meeting of the Letcher County Medical and Dental Society was held Tuesday night, March 27th, 1951 in the Whitesburg City Hall. The following members were present: Drs. Lundy Adams, President, Gerald L. Morin, Lee Moore, Carl Pigman, R. D. Collins, E. G. Skaggs.

Dr. Lundy Adams presided and called the meeting to order. Minutes of the February meeting were read and approved.

The business session followed and after hearing Dr. Lee Moore explain how badly they needed chairs for the Whitesburg City Hall, the Society unanimously voted to purchase six chairs at \$6.00 per chair (\$36.00) and present them to the City of Whitesburg, as our plans are to use this place as a meeting place for our local society.

Dr. G. L. Morin, Jenkins, Surgeon of Sharon Heights Hospital, brought his projector and showed three films on Surgery. Two films were on Caesarian section and one film on Hernia operation and these were well enjoyed by the doctors present.

We regret that illness and other matters prevented such a low attendance. Our President, Dr. Lundy Adams, served refreshments and the meeting adjourned at 10:00 p.m.

The next meeting will be held on April 24.

R. Dow Collins, Secretary

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### MUHLENBERG

The Muhlenberg County Medical Society met February 16, 1951. The meeting was called to order by the President, Dr. G. L. Richardson and minutes of the preceding meeting were read and approved.

No new business was presented, nor were there any communications.

Dr. R. E. Davis presented a paper on "Coccyxodynia," which enjoyed general discussion.

On motion the meeting was adjourned.

G. F. Brockman, Secretary

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### MUHLENBERG

The Muhlenberg County Medical Society met March 2, 1951. The meeting was called to order by the President, Dr. G. L. Richardson and the minutes of the preceding meeting were read and approved.

The following members were present: Drs. G. F. Brockman, G. L. Richardson, G. L. Simpson, F. M. Wilson, H. H. Woodson, and J. P. Walton.

Dr. J. P. Walton presented a paper entitled, "Acrodynia."

There being no further business the meeting adjourned.

G. F. Brockman, Secretary

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### SCOTT

The Scott County Medical Society held its regular monthly meeting Thursday, March 1, 1951 at the John Graves Ford Memorial Hospital with the following members present: Drs. W. S. Allpin, L. F. Heath, E. C. Barlow, D. E. Clark, A. F. Smith, H. G. Wells and F. W. Wilt.

Dr. Henri LeClaire, Cincinnati, Ohio, was a guest of the Society and he proposes to visit Georgetown once a week and read X-rays that require his attention, give deep X-ray or radium as the case may be.

There being no further business the meeting adjourned.

H. V. Johnson, Secretary

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**The incipient lesion of pulmonary tuberculosis** of limited extent is practically always of unstable character and in a large proportion of the cases it progresses to advanced and destructive disease. There is reason to believe that the majority of cases of manifest clinical tuberculosis have their origin in these seemingly inconspicuous, small lesions. David Reisner, M. D., Am. Rev. Tuberc.

## News Items



**R. HAYNES BARR, M. D.**  
Owensboro

Dr. R. Haynes Barr, Owensboro, was elected president of the Owensboro Chamber of Commerce for the year 1951. He has served on the city Board of Education and is president of the Owensboro Country Club. He is Chairman of our Educational Committee and is councilor of the second district.

Dr. Joseph R. Griffitt, formerly of Nicholasville, has moved to Mt. Washington to take over the practice of Dr. E. N. Rush who has been called into service. Dr. Griffitt was graduated from Transylvania College, Lexington, and served with the U. S. Army for three years. He was graduated from the University of Louisville School of Medicine in 1950.

Six Kentucky physicians attended the New Orleans Graduate Medical Assembly March 5-8, 1951. They were M. A. Coyle, M. D., Springfield; Leslie C. Dodson, M. D. and Horace Harrison, M. D., Owensboro; John B. Floyd Sr., M. D. and J. K. Newton, M. D., Outwood; and Milo Schosser, M. D., Benham.

Dr. Ojar Podins, 39, a native of Latvia, has been appointed assistant to Dr. W. W. Richardson at the State Tuberculosis Hospital, Paris. Dr. Podins was born in Riga, Latvia, and was graduated from the Medical Department of the University of Latvia. He was assistant physician in the University's hospital until 1944, when he assumed duties at the Municipal Hospital at Liepaja, Latvia. He was sent by the German Government in 1944 to a Nazi labor camp where he served as a physician until the

fall of the Reich. Since the war he has practiced in a displaced persons camp at Bad-Worishofen, Germany and later at a tuberculosis hospital at Heilbronn, Germany. Dr. Podins recently served a year's internship at the Swedish Convent Hospital in Chicago.

Dr. H. G. Sargent, practicing physician at Kevil, Ballard County, sold his office and equipment to Dr. J. M. Hunt, Jr., and volunteered for the Air Force. He was rejected because the Air Force quota was full. Meanwhile, the Atomic Plant located near Kevil bringing in a large influx of people to Ballard County and the surrounding communities. The draft board has considered this area essential and the physician's need very great. Dr. Sargent has bought the office and equipment from Dr. O. C. Cooper, Barlow, where he has maintained offices in Barlow and Wickliffe for the past three years, dividing his time between the two towns.

Dr. Irvin H. Sonne, retired Louisville physician, has purchased Methodist Evangelical Hospital and will operate the institution as a home for old persons. The hospital was sold because of its small 75 bed capacity and increased costs of operation. The Methodists are planning to build a two million dollar hospital in the near future in Louisville.

Many doctors will regret the passing of the Old Deaconess, but will welcome its new geriatric service.



**W. R. MINER, M. D.**  
Covington

Dr. W. R. Miner, Covington, was elected president-elect of the Southeastern Section of the American Urological Association at its meeting in Memphis. Dr. Miner was graduated from Rush Medical College, Chicago, in 1927. He is a member of the American Urological Association, and a Fellow of the American Medical Association. He was Orator in Surgery of the Kentucky State Medical Association meeting in 1949.



## *In Memoriam*



**JOHN H. BLACKBURN, M. D.**

**Bowling Green**

**1876 - 1951**

Dr. John H. Blackburn, Bowling Green physician, died unexpectedly at his home Saturday, February 17, 1951. Dr. Blackburn was born at Woodburn, August 7, 1876. After graduating from Franklin High School, he entered Vanderbilt University and received his M. D. degree in 1899. He interned at Nashville General Hospital and did post graduate work at New York Polyclinic prior to opening his practice in Bowling Green in 1900.

Dr. Blackburn entered military service in June, 1917 and served as chief of surgery of a base hospital in France. He was discharged a Lieutenant Colonel and held that rank in the reserves at the time of his death. At the close of World War I, he returned to Bowling Green and opened the Blackburn hospital, which he operated until 1926. He had carried on a private practice since.

Dr. Blackburn was a member of the Warren-Edmonson Medical Society, Third District Medical Society, in which he had held several offices. He was a fellow of the American College of Surgeons since 1915. Dr. Blackburn served as president of the Kentucky Medical Association in 1928 and as a member of the State Board of Health from 1934 to 1945.

**A. O. SISK, M. D.**

**Lexington**

**1874 - 1951**

Dr. Amplias Owen Sisk, Lexington, died January 28, 1951 of a heart attack. He received his education in Hopkins county schools and was graduated from the Louisville College of Medicine in 1898. Following his graduation Dr. Sisk was associated for a time with the late Dr. J. D. Sory, Madisonville, moving then to Earlington to join the medical staff of the St. Bernard Coal Company.

In World War I Dr. Sisk volunteered for service, and as a captain in the engineer corps of the 113th division, he was stationed for a time at St. Nazaire, France. Returning to Earlington following the war, he moved to Lexington in 1925, to practice medicine.

Dr. Sisk received a fifty-year button from the University of Louisville School of Medicine in 1948 for his half-century of service as a practitioner.



**WILLIAM V. NEEL, M. D.**

**Henderson**

**1878 - 1951**

Dr. William V. Neel died January 30th, 1951. He was born in Union County on February 8, 1878. He was graduated from the University of Louisville Medical Department in 1902, and took his post-graduate work at Harvard. Dr. Neel had been a physician in Henderson for forty-eight years, and it was through his efforts that a full-time health unit was first established in Henderson County. He was chairman of the first Crippled Children's clinic held in Henderson and for many years was president of the board of health.

The following resolutions were passed by the Henderson County Medical Society:

"BE IT RESOLVED, whereas Almighty God in His all wise and merciful providence has seen fit to remove from our midst William V. Neel, a member of the Henderson County Medical Society for forty-eight years, we, the Henderson County Medical Society, and those he served so faithfully throughout a long and useful life in the practice of medicine in this community mourn his loss.

Easy Fatigability . . .

Colonic Tenderness . . .

Diarrhea,  
Short Attacks . . .

Constipation . . .



**In Amebiasis** — "It must be assumed that the carrier state is an active stage of the disease and deserves effective treatment. . . . It is accepted practice, therefore, to give the carrier an oral amebicide that will not inconvenience him or interfere with his normal activities. A full course of Diodoquin fulfills this purpose. . . ."



—Selesnick, S.: *The Treatment of Amebiasis*, Connecticut M. J. 12:946 (Oct.) 1948.

A potent oral amebicide, Diodoquin can be taken readily by ambulant patients for treatment of acute or latent forms of amebiasis.

**DIODOQUIN**® (diiodohydroxyquinoline) is relatively non-toxic, may be administered over prolonged periods and is well tolerated.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**



"BE IT RESOLVED, that it is with esteem and admiration for the wonderful example William V. Neel has left as a legacy to the Henderson County Medical Society. He ministered to those sick of body and mind with skill and was always faithful to the responsibility imposed on his profession to give of his knowledge and skill to all who are in need of medical care.

"BE IT FURTHER RESOLVED, William V. Neel, a man of culture and refinement, a man who added luster to his profession, we, his colleagues, feel that our profession and community have lost a friend, counselor, a Christian gentleman and a beloved physician.

"BE IT FURTHER RESOLVED, that the Henderson Medical Society extends to his widow and family our deep-felt sympathy in their bereavement and our prayer is that they may have that peace that passeth all understanding and only comes from our Creator, Almighty God, who doeth all things well."



**L. R. KELLAM, M. D.**

**Morgantown**

**1919 - 1951**

Dr. L. R. Kellam, Morgantown, died January 31, 1951. Ill only a few hours, Dr. Kellam's death came as a shock to his family and many friends.

He was born in Culver, Indiana, August 14, 1919 and was graduated from the College of Physicians and Surgeons Medical Center, New York in 1945. He served an internship at the Methodist Memorial Hospital in Brooklyn, New York. He entered the service during World War II, as flight surgeon, and commanded the Base Hospital, Ft. George Wright, Spokane, Washington. He served at the disastrous Texas City explosion in April 1947.

On January 10, 1949 he initiated a successful practice of medicine in Morgantown and was active up to a few hours before his death.

The following resolutions were passed by the Muhlenberg County Society:

WHEREAS: The life of Dr. L. R. Kellam of Morgantown, Kentucky, was terminated January 31, 1951, and

WHEREAS: Dr. Kellam was a true pioneer

in spirit, willing to suffer hardships in caring for the ill in a strictly rural setting, and

WHEREAS: He was a scientific physician and conducted an excellent quality of medical care for his patients, and

WHEREAS: He was a consecrated Christian gentleman and an outstanding citizen of Butler County, and

WHEREAS: He was a devoted and faithful husband and father, therefore,

BE IT RESOLVED: That the Muhlenberg County Medical Association, in which he held an associate membership, express its sorrow at his sudden and unexpected death and that a copy of this resolution be entered in the books of this organization and a copy sent to the family of the deceased.

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**LOGAN T. LANHAM, M. D.**

**Mt. Olivet**

**1905 - 1951**

Dr. Logan T. Lanham, prominent physician of Mt. Olivet, Robertson County, for over twenty years, died suddenly February 3, 1951 of a heart attack.

Dr. Lanham was born at Cincinnati, February 22, 1905. He attended Millersburg Military Institute at Millersburg, and was graduated from Deming High School at Mt. Olivet in 1924. He was graduated from the University of Louisville School of Medicine in 1930 and served his internship in Indiana following which he went to Mt. Olivet where for two years he served as County Health Officer, and thereafter faithfully served for twenty-eight years as a practicing physician.

---

**JAMES C. GRAHAM, M. D.**

**Greensburg**

**1878 - 1951**

Dr. James C. Graham, Greensburg, born October 2, 1878, died February 26, 1951 at the age of 72 of a cerebral hemorrhage.

Dr. Graham was graduated from the University of Louisville Medical Department, 1911. He was commissioned a First Lieutenant December 12, 1917 and served with the French under General Gourand until he was wounded at Champaign and was discharged February 10, 1919. Dr. Graham was examiner for Green County in World War II.

He was a member of the American Medical Association and the Kentucky State Medical Association for thirty-nine years and was Secretary of the Green County Medical Society at the time of his death.

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Medical Director

T. J. SMITH, M. D., Associate



## BOOK REVIEWS

**THE AUDIOLOGY CLINIC, A MANUAL FOR PLANNING A CLINIC FOR THE REHABILITATION OF THE ACOUSTICALLY HANDICAPPED** by Moe Bergman, Ed. D., Chief Audiologist, Audiology Clinic, New York Regional Office, Veterans Administration. *Acta Oto-Laryngologica Supplementum LXXXIX*. Oslo, Norway: Aas & Wahls Boktrykkeri. 1950. Price \$1.00.

The stimulus for this monograph was the lack of organized information and guidance on the problems of activating an auditory rehabilitation program.

This monograph is intended as a guide for the establishment of well rounded and effective audiological services. The ideal in blueprints is presented but it is pointed out that in planning such a clinic an analysis of functions, services and activities of the clinic should be accomplished as the first step and then the clinic planned accordingly. Mr. Bergman presents the following considerations: (1) The special construction required, (2) the selection of electro-acoustic equipment, (3) the organization of an instructional program, and (4) the assembling of a professionally competent staff. The clinical phase of audiology is presented as a co-operative approach to the problems of the acoustically handicapped, calling upon the knowledge and skills of many different specialists.

This manual would be invaluable in illuminating the many considerations involved in planning such a clinic by individuals and organizations interested in the development of the field of Audiology. It would be a particular aid to university speech and medical departments which in most cases sponsor such units.

Copies of this monograph may be obtained by writing to The Audiology Foundation, 1104 South Wabash Ave., Chicago 5, Illinois.

**PARACELSUS, Magic into Science** by Henry M. Pachter. Publishers: Henry Schuman, Inc., 20 East 70th Street, New York 21, New York. April 10, 1951. Price \$4.00.

The author has done full justice to this fascinating subject. His work is the product of years of research, begun in Europe and fin-

ished in this country. He has drawn upon new documentary material unavailable to earlier biographers and has brought to bear upon his subject the new insights of modern psychiatry. The modern understandings he applies help to clarify age-old problems such as materialism vs. idealism, the rational vs. the irrational. To themes that have been obscured by mystical speculation he has brought a clear and probing mind and a style notable for its vigor and literary distinction.

Above all things he brings to vivid life one of the most exciting periods in world history, the early Renaissance when men were throwing off the mental fetters of the middle ages and groping toward reason. Apart from his special significance in science history Paracelsus ranks with the most representative figures of that remarkable age that produced Descartes, Rabelais, Montaigne, Dante.

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**PIONEER DOCTOR** by Lewis J. Moorman, M. D. Publishers: The University of Oklahoma Press, Publishing Division of the University, at Norman Oklahoma. 1951. Price \$3.75.

**PIONEER DOCTOR** is the human story of a half century of medical practice, from the early days in Oklahoma.

The experiences recounted run the gamut of human ills and situations of childbirth in a barn loft, of the "faith healer" who infected a whole community with itch, of the mother who was sure her child had a case of the "gobacks." The book tells about Indians, who turn out to be not always as robust as outdoor living would lead one to think; the dramatic and horrifying effects of gunshot and knife wounds; and the spiritual response of patients stricken with tuberculosis, the field in which the author has achieved a well-deserved international reputation.

This volume stands on its own merits as a piece of entertaining and informative writing, but its social and cultural significance will not be missed by even the most casual reader. For there is apparent here a tremendous transformation as the countless young doctors, of which Dr. Moorman was one, went out from Louisville College, the school which covered the plains with horse and buggy doctors. Here, too, will be found perhaps the best statement of faith that has been made for the general practitioner in our society.

# *The* JOURNAL *of the* Kentucky State Medical Association

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## HEADACHE: TRIGEMINAL NEURALGIA

H. Lester Reed, M. D.

LOUISVILLE

Trigeminal Neuralgia, when fully developed, is characteristic. This is a progressive, paroxysmal painful disorder of one side of the face, occurring usually in middle-to-late life. An over-all attack may last days to weeks. The duration and severity increase as does the length of sickness. Paroxysmal attacks of pain are ordinarily cataclysmic in onset and limited to the zone of the 5th nerve. Frequently the upper face, jaw, and tongue are included. Trigger areas are common and such maneuvers as washing the face, brushing the teeth, attempting to eat, or combing the hair may precipitate an attack. There is often lacrimation and nasal discharge on the affected side during the pain. Aside from the trigger areas, which are sometimes demonstrated, and the inclination of the patient to immobilize the affected side of the face, there are no definite signs. X-rays are of little help. Treatment consists of toleration of the disorder, efforts at injection of the 5th nerve, or ganglion with alcohol, or surgical section of a portion or all of the fifth nerve. Usual medication fails to give relief of this type of pain.

### **Ninth Nerve Neuralgia**

Ninth Nerve Neuralgia is similar to 5th nerve type, except for the location of pain. Pain is located in the throat, tonsillar region, and ear. This is precipitated, primarily, by swallowing, or may be of spontaneous onset. Ninth nerve section ordinarily gives relief. This is an uncommon disorder.

### **Cervical Neuritis**

Cervical Neuritis is a disorder of pain in the neck and posterior portion of the

head, related to some type of cervical nerve-root disorder. Ordinarily pain is stated to originate in the occipital area and radiates forward; either over the vertex, or more commonly into the temporal region. The most common cause is some type of trauma, with or without X-ray evidence of spine abnormality. Pain may be unilateral, but is commonly bilateral. Frequently there is the complaint of tightness or fullness in the upper neck. It is noted that certain movements of the neck frequently increase the headache. The temporal type of pain is often throbbing. A not uncommon injury is acute flexion and extension of the head and neck in automobile accidents. The onset of pain may be delayed regarding the time of trauma. Clinically one can usually precipitate the complaint by rotation of the head on the neck, or by hyperextension or flexion. Sometimes gentle pressure on the vertex with the patient in a sitting position markedly increases the pain. Relief is obtained by producing head traction while the patient is sitting. This is often dramatic. X-ray studies of the cervical spine may demonstrate straightening of the loss of the usual lordosis or arthritis. It is uncommon to find other bony abnormality. Management usually is conservative. Relief can be obtained by sleeping on a hard bed or wearing a neck brace. In more severe syndromes, it may be necessary to immobilize the patient in bed with head traction for an extended time.

### **Intracranial Mass**

Intracranial Mass refers to any type of expanding lesion in the cranial cavity, whether it be tumor, infection, or hemorrhage. The chronic lesions cause most diagnostic difficulty. The onset of pain



is often insidious, making its appearance over weeks or months. The patient may state: "I suddenly realized I had been having headaches for some time." The pain is often generalized and without specific localization. On the other hand when an individual states that progressive pain in the head is at a given and recurrent, specific location, I tend to be very suspicious of a focal mass. Characteristically the pain appears on awakening and is present before getting out of bed, only to disappear as there is activity and as the day wears on. Position comes to play a part in producing or relieving the pain. The position of comfort depends somewhat upon the location of the mass. The individual will frequently state that there are specific postures which he can not assume without the onset of pain, or nausea, and sometimes vomiting. It is rare that headache resulting from an intracranial mass, once it has made its appearance, will subside spontaneously for any appreciable time. Before the onset of frank neurological signs it is often impossible to recognize these lesions for certain. Diagnostic measures of help include X-ray studies, spinal fluid examinations, frequent study of the optic fundi; the electroencephalogram.

### Post-Traumatic

Post-Traumatic Headaches are extremely difficult to evaluate. Early pain, or throbbing in the head, following an injury, in the absence of lethargy, frank neurological signs, or alteration of other vital signs, is ordinarily self limited. Persistent pain, however, even in the absence of neurological signs, may be the only evidence for intracranial hematoma.

Complaints of headache and dizziness which so often follow mild head injury, as a chronic complaint, are hard to evaluate. Much of this type is on a functional and apprehensive basis in my opinion. There is however, a pattern of these complaints which seems to be fairly constant and real, and in emotionally stable people. I do not know the cause, and know of very little to do about it. These individuals are entitled to complete work-up in the form of X-rays, electroencephalogram, and in some instances, air studies. At times, one will encounter electrical convulsive phenomena, which can be treated and improved, in part. Air studies need not be done on many, but at times are warranted.

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## PATHOLOGY AND PHYSIOLOGY OF HEADACHE

Arthur T. Hurst, M. D.

LOUISVILLE

Headache is one of the commonest of complaints occurring in a great variety of pathological and functional situations. With all of the study that has been made by various investigators, the mechanisms producing headache are far from being clearly understood. We are indebted to Wolff and his associates for a considerable amount of our knowledge of the pathological anatomy and physiology of headache. They were able to determine during operations the pain sensitive structures and the non-sensitive structures. The pain sensitive structures are the scalp, galea, fascia and muscles, periosteum (variable), main trunk dural arteries, anterior meningeal arteries, posterior meningeal arteries, middle meningeal arteries, the dura of the floor of the anterior fossa, dura of the olfactory groove and roof of

the orbit, dura of the posterior fossa, superior surface of the tentorium, superior sagittal sinus and its tributary veins near the sinus, transverse sinuses, superior petrosal sinus, torcular herophili, straight sinus, occipital sinus, basal blood vessels with the proximal portion of the cerebral vessels, ninth, tenth, eleventh and first three cervical nerves.

The non-sensitive structures are the cranial bone, diploe, emissary veins, small branches of the anterior and posterior meningeal arteries, supratentorial dura (except at its base), middle fossa dura, falx along the superior sagittal sinus, Pacchionian granulations, venous lacunae, inferior sagittal sinus, inferior cerebral veins, pia-arachnoid, parenchyma of the cerebrum and the cerebellum and the vessels therein, olfactory, optic, and auditory nerves, lateral third and fourth ven-

tricles, choroid plexuses and the aqueduct of sylvius.

### Mechanisms Involved

According to Wolff, the principal mechanisms concerned are inflammation, traction, displacement and distension of the pain sensitive structures. The neural pathways of the pain sensitive structures of the head are divided distinctly into supra- and infra-tentorial groups. The cranial and upper cervical nerves supply these areas. Constriction of an artery does not cause pain but stretching gives rise to localized pain and occasionally to nausea so long as the stimulus is continued. Throbbing is produced by alternate stretching and relaxing. Although the ventricles are insensitive to pain, either rapid emptying or over-distension of the lateral ventricles will cause a diffuse bilateral headache and stretching of the third ventricle causes pain over the entire head probably from traction on the basilar arteries.

A disturbance in the hydrodynamic mechanism within the head accounts for the majority of headaches. The pain sensitive structures may be distorted by many factors. The brain volume may be altered, the cerebrospinal fluid pressure, the blood volume or the peripheral vascular tone increased or decreased.

### Vascular Origin

It is believed the majority of headaches are of vascular origin. It is thought that vasoconstriction occurs first, followed by vasodilatation and congestion of the pia mater. The initial vasoconstriction and the resulting anemia may also result in edema and a rise in intracranial pressure. The potent vasodilator substance, Histamine, when administered produces dilatation of the vessels at the base of the brain according to Schumaker and Wolff. In hypertension the peripheral vascular tone is increased without equal diminution in effective blood volume and cardiac output, the increased vascular excursion causing headache.

In migraine, menstruation and relaxation periods, hemoconcentration, decreased blood volume and decrease in peripheral vascular tone occur. Treatment, therefore, consists of increasing the blood volume or restoring peripheral vascular tone by strong, smooth muscle stimulants which decrease the excursion of the cerebral vessels.

Increased intracranial pressure is apparently neither a prime factor nor an essential one. The headache associated with either decreased or increased intracranial pressure results from traction displacement of pain sensitive structures. Increased intracranial pressure produces traction on tributary veins from the cerebral cortex to the dural sinuses and on the large pial and cerebral arteries at the base of the brain or middle meningeal arteries and causes herniation of the cerebellum which in turn produces traction on the occipital sinus and displacement of the cervical roots.

### Migraine

In migraine, according to Bromwell, the aura is associated with spasm of the pial vessels, the headache with vasodilatation and possibly with localized edema. Migraine in some cases appears to be a form of allergy producing intracranial urticaria. Riley, Brickner and Kurzrok have shown evidence that hypersecretion of the gonado-tropic hormone of the pituitary may be a factor in the onset of the migrainous attack.

### Emotional States

The headache produced by excitement, emotional states and reflex action from various parts of the body can be readily understood upon the basis of a vascular mechanism. Variation in blood volume or in intracranial vascular tension play significant roles here. Emotionally tense people are prone to hyperventilate producing alkalosis inducing headache. A common cause of headache is constipation. Alvarez has pointed out that the headache is relieved very quickly by defecation, so it is apparently reflex rather than toxic in origin.

### Hypoglycemia

Hypoglycemia headaches occur in patients with flat glucose tolerance curves and are often relieved by dietary measures. Dreisbach and Pfieffer have shown that caffeine withdrawal headaches are probably due to increased blood volume.

### Intracranial Pathology

Headaches from intracranial pathology may be due to the irritation of sensitive nerve endings in the immediate neighborhood of the lesion with or without increase in intracranial pressure. Elsberg has pointed out that sudden changes in



intraventricular pressure are likely to cause headache quite apart from any significant change in general intracranial pressure. The severe headache following withdrawal of cerebrospinal fluid by lumbar puncture, he considers due to lowered pressure within the third ventricle. In encephalography when the injected air enters the third and fourth lateral ventricles, headache occurs, varying in site according to the location of air in the ventricles.

Headache may be due to neuralgias of the trigeminal, facial, intermediate, glossopharyngeal, vidian, sphenopalatine and geniculate nerves and of the tympanic plexus. Areas supplied by the vagus nerve which is segmentally related to the trigeminal may produce referred pain to its terminals. Intracranial branches of the

vagus also probably contain pain fibers.

### Eye Strain

Eye strain is a very common cause of headache. Reflex vasomotor changes within the cranium and pain referred from the eye to the terminals of the trigeminal nerve are probably the chief causative factors in visual defect headaches. The strain of holding the head in a certain position to avoid further strains of changing accommodation may produce an occipital myalgia.

Headache may occur from pathology in the neck region. Occipitonuchal pain may be produced by hypertonicity of the neck muscles, local rheumatoid myositis and fibrositis, neuritis and arthritis. These causes of headache are frequently overlooked.

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## HEADACHE DIAGNOSIS

Ben H. Hollis, M. D., F. A. C. P.

LOUISVILLE

Since one seldom learns much about the nature of a particular headache from examining the patient, the wise physician will depend mainly for his diagnosis on a carefully taken history and his knowledge of the several syndromes. He can probably recognize quickly the common type of harmless headache due to fatigue or nervousness. This will never disable the patient, and usually it can be helped by the taking of acetylsalicylic acid, acetphenetidin, acetanilid, antipyrine, amidopyrine, alcohol or other pain-relieving drugs. That the ache is not severe will be apparent also from the fact that the patient can go to sleep easily at night. Often it will be found that the patient is a headachy person who reacts to any difficult or fatiguing situation with a headache.

The great difficulty in many cases arises from the fact that in a headachy person several causes, individually or collectively, can produce a headache and one which is not typical of anything. For instance a migrainous woman contemplating divorce can get into such a nervous state that her headache becomes constant, and no longer is influenced by gynergen or anything.

### Diagnostic Difficulties

A good example of the diagnostic difficulties encountered is to be found in the case of a neurotic migrainous woman who after fretting over family troubles got to having daily headaches which were not typically migrainous. Sometimes there was a suggestion of a histaminic type of pain, and it was found that an injection of histamine could throw her into a spell. Desensitization treatments with histamine, together with rest, caused her to go home apparently cured. Later the patient returned with severe daily headaches which no longer responded to treatment either with histamine or gynergen (ergotamine tartrate). This time an allergic element was discovered, and she responded well to the removal of milk from her diet. It is the presence of these mixed, puzzling and borderline types of headache with several causes that gives the physician most of his diagnostic troubles.

In the case of a woman it may be found that the headaches come mainly at the menstrual period, when breakfast with coffee has been delayed, or when there is constipation or much nervous tension.

### Eyestrain

Headache due to eyestrain is most likely

to come toward the close of the day or after much reading or fine sewing. The early morning headache of the person with hypertension is coming to be well known. This headache is one which appears on awakening, or awakens the patient during the early morning hours, has its greatest intensity before arising, and passes away either immediately after breakfast or during the morning to reappear in the same manner day after day for considerable periods. Location and intensity of pain varies, but the most severe resembles bad migraine, with nausea and vomiting.

### **Orthstatic**

Orthstatic headaches come on abruptly on arising (or on other sudden change in posture) and are accompanied by exhaustion. Both the headache and exhaustion disappear gradually during the day. Deficient sweating, polyuria when recumbent and syncope are common. The Flack test is helpful in the diagnosis. In this test the patient blows the sphygmomanometer up to 40mm. and holds it for 25 seconds. The normal patient can hold it but the patient with poor venous return experiences headache, tachycardia, fainting and collapse in about 10 seconds. When the patient stands suddenly there is a characteristic fall in the blood pressure. Sinusitis usually produces more of a pain in the face and a feeling of expanding pressure in some sinus than a headache.

### **Hypertonic**

Hypertonic neck muscles may refer pain to any area, even to one strictly hemicranial, but the pain is usually occipital radiating as far as the frontal region and down between the shoulders. This type of headache never awakens the patient. He often finds relief in sitting with head forward, chin in hands. Anorexia, nausea, vomiting and vertigo are common, and the patient often refers to the throat as the source of the trouble. Examination shows painful nodules in the neck muscles, muscle spasm, cutaneous hypersensitivity or pain in the sternoclavicular or acromioclavicular joint or occipital nerve. The headache is often accompanied by other signs of allergy, vasomotor imbalance or psychoneurosis. Most of these patients are usually susceptible to cold, and exposure to cold drafts or chilling often brings on the headache. Arthritis, eye strain and nasal infections are common.

### **Migraine**

The migrainous headache is often distinctive. It comes usually in a sensitive, wide-awake, intense, eager sort of woman; it is sometimes preceded by partial blindness which lasts from twenty to thirty minutes; it is often unilateral, usually throbbing, and it is often associated with nausea, anorexia, perhaps vomiting, chilliness, dizziness or numbness and in bad cases, with depression, apathy and misery. One glance at the patient in such an attack is enough to make the diagnosis. It is helpful in puzzling cases to find that the patient had "bilious" or "cyclic" vomiting spells in childhood, that she (the patient is usually a woman) was free from the headache during pregnancy, and that the attacks are brought on by such things as nervous tension, anticipation, excitement, menstruation, bright lights or smells, a close room, traveling or the eating of certain foods. It is of diagnostic value to learn that the headache, when severe, is not helped by drugs like acetylsalicylic acid but is relieved by an intramuscular injection of ergotamine tartrate. Typical is the story that the woman gets a headache when she tries to have a dinner party.

### **Histamine**

The histamine headache usually begins in later age groups, are hemicranial of short duration usually under one hour and tend to awaken the patient one or two hours after falling to sleep. The pain is excruciating, constant, boring and involves the eye, temple, neck and face. There is profuse watering of the eye with congestion, rhinorrhea or stuffiness of the nose, increased surface temperature of the nose and often swelling of the temporal vessels. It can be reproduced by 0.1 or 1.2 mg. histamine injected subcutaneously or intravenously and can be relieved by epinephrine. In contrast to migraine, there is no association with menstruation, no familial history, no nausea or visual disturbances. There is a history of more recent onset, of short attacks and of onset late in life. There are no trigger zones as seen in trigeminal neuralgia. The pain follows the arterial rather than the nerve distribution.

The constant headache, which is present all day and day in and day out, is seen usually in a healthy-looking, young person and probably is neurotic in origin.

### **Nervous**

Nervous headaches are capricious, bi-



zarre and follow no definite pattern as to time, location, duration, exciting factor or nature of the pain. As psychoneurotic symptoms they are diverse and multi-form. The duration may serve to identify them. As a rule, headaches from organic causes do not last "for years" or "all my life." Associated disturbances such as light-headedness, sweating of the palms, globus, precordial pain, hyperventilation and stiffness and tenderness of the neck muscles may help to identify the origin of the headache. There is a tendency for the patient to amplify and to exaggerate the pain, to describe it in dramatic terms or to boast of the suffering he or she is forced to endure.

One almost never finds any local cause for it, and it is highly resistant to treatment. Sometimes such headaches seem to be equivalents of fatigue or boredom.

### Allergic

The allergic headache may come during the night or in the morning. It may be dull and indefinite, a sort of heaviness, and it may follow a night of poor sleep and nightmares due to the bad effect of the food. In some severe cases there may be a sort of meningism with jabbing pain when the patient coughs or sneezes.

The let-down headache often seen in a migrainous person is likely to come Saturday noon when work stops.

A typical hunger headache is that of the priest who cannot eat until he has celebrated an eleven o'clock mass.

A terrible headache, which has come suddenly, should make one think of the rupture of a tiny congenital aneurysm on one of the arteries of the circle of Willis. In such case the presence of blood in the subarachnoid space will usually produce signs of meningeal irritation such as a positive Kernig sign, and examination of the cerebrospinal fluid will show the presence of blood.

### Brain Tumor

Naturally, if one suspects brain tumor, one looks for a history of progressive worsening of the symptoms with the passage of time; one looks for character changes, a choked disk, loss of vision and disturbances in the functions of the several cranial nerves. A lasting defect in vision may be found with a brain tumor involving the occipital lobes. Temporary scotomas lasting from twenty to thirty minutes are due to migraine.

A brain abscess may not produce headache unless it is associated with meningitis or periostitis.

Anorexia, nausea and vomiting can be found with almost any type of severe headache. Vomiting without nausea may occur with brain tumors, particularly those of the posterior fossa.

Temporary polyuria is likely to occur with migrainous headaches, and constant polyuria may go with tumors of the third ventricle.

Defects in color vision and colored rings about lights may occur with the headache that is due to glaucoma.

### Aspect of Patient

The aspect of a patient during a headache. One glance at a patient with severe migraine may be enough to make the diagnosis because the mental misery is so obvious. The patient is apathetic, uncommunicative and completely "whipped." The eyes are glazed. The patient wants to get away from everyone and to be left alone in a darkened room. Some of these symptoms may appear with the headache of brain tumor. They are absent in most other types of headache.

### Loss of Sleep

When a headache is so severe that it does not permit rest, it should be looked upon with concern; ordinarily mild headaches do not interfere with sleep.

### The Effect of Analgesics

Something usually can be learned by asking if the headache is helped by the usual analgesics in the aspirin class. Morphine may be necessary to control the severe headaches of meningitis, migraine, ruptured aneurysm or certain fevers. The headache of brain tumor seldom is intense enough to require the use of opiates.

### The Effect of Ergotamine Tartrate

The fact that ergotamine tartrate terminates a headache almost proves that it is migrainous in character. About the only type of headache that this drug might help would be that of high blood pressure. It is said also to help the headache that follows spinal puncture.

### Throbbing

The throbbing or pulsating headaches are those of migraine, fever, hemangiomas and sometimes, high blood

pressure. The headaches of brain tumors and meningitis generally are steady.

### **What Can Be Learned From the Site of the Headache?**

A subdural hematoma is likely to produce a headache of considerable intensity usually localized over or near the site of the lesion, most commonly over the frontal or parietal area. It usually comes for some time each day and lasts for weeks or months or longer. Naturally, one can guess sometimes from the location of pain that a certain sinus is inflamed.

### **Tenderness of the Tissues**

During migrainous headaches and for some hours thereafter there is often hyperalgesia or tenderness near the large arteries on the outside of the head in the affected region. The whole scalp may be so tender that the hair cannot be brushed. There may be tenderness of the skin of the face as a result of trouble in the nose or sinuses. Muscles in the back of the neck may become sore with "induration" or fibrositic headaches.

Straining at stool or coughing is likely to increase all types of headache except those due to muscle tension and spinal drainage. Photophobia can accompany migraine, meningitis, severe disease in the nose and sinuses and in the eyes, brain tumor and nuchal muscle spasm. Headache is a bad sign in children, but the trouble may be due to allergy, sinusitis or migraine.

### **Tests to Be Made**

In every case of severe headache not typically migrainous, beside the general physical and laboratory and roentgenological studies, a neurological examination should be made, and the eyegrounds should be examined by an expert. He will look for a choked disk or the changes that go with severe hypertension, nephritis or diabetes. The ocular tension

should be noted in order to rule out glaucoma. Refraction and tests of muscular balance should often be carried out. Electroencephalograms may be helpful in uncovering a headache of psychomotor origins.

Stereoscopic roentgenograms of the skull should be obtained both in the lateral and the anteroposterior directions, and special films should be taken of the sinuses. Even in many of the cases of brain tumor nothing will be seen, or there may be thinning of the skull and signs of pressure here or there. Hyperostosis of the frontal bones is not in itself a cause of headache. No significance need be attached to calcification of the falx, of the pineal body or of the choroid plexuses. Roentgenologically demonstrated calcification of the internal carotid arteries may be of some significance when one suspects cerebral arteriosclerosis. Small changes in the sella turcica usually can be ignored.

Increased density of the shadows of the nasal sinuses does not necessarily mean that inflammation is present; it may mean only that it has been there in the past. A rhinologist must interpret the films in the light of what he finds in the nose. He may want to cocaine the sphenopalatine ganglion, shrink a spur or wash out a sinus to see if that has any effect on the headache. Often one can almost rule out sinusitis by noting that at the end of the day the patient has a clean handkerchief. Most patients, who fuss over postnasal drip, have no infection in the nose or sinuses.

Woltman has pointed out that many physicians fail to get useful information because they do not palpate the head. In cases of headache they may find patches of fibrositis in the muscles of the scalp or nuchal region, and in rare cases they may discover a patch of arteritis nodosa.

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Fundamentals of Internal Medicine: Yater.

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The following hit at the water cure was made by Charles Lamb, and no one but himself could have had so quaint a conceit: "It is," he said, "neither new nor wonderful, for it is as old as the Deluge, which, in my opinion, killed more than it cured." Boston M. & S. J., November 6, 1850.

A roentgenographically normal chest in a person over 40 does not eliminate the possibility of pulmonary tuberculosis developing in the future. Incipient pulmonary tuberculosis in persons over 40 may be much more common than is generally supposed. Aaron D. Chaves, M. D., Am. Rev. Tuberc.



## MEDICAL TREATMENT OF HEADACHE

Carlisle Morse, M. D., F. A. C. P.

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More treatment is given for headache than for anything else. von Storch said: "If I wished to show a student the difficulties of medical practice I should give him a headache to treat." Accurate diagnosis is the fundamental first step in treatment. Good patient-physician relationship is essential.

### Ordinary Headache

Headaches of the ordinary type undoubtedly are most common, and are related to irregularities of living, irregular sleep and rest, indiscretions of diet, overindulgency in alcohol, or overfatigue. The patients usually obtain relief from aspirin 0.3 to 0.6 grams (5 to 10 grains) or two empirin compound tablets, repeated in an hour. Codeine sulfate 30 mg. ( $\frac{1}{2}$  grain) may be combined with either of those in the severe types, but there is danger of addiction where it is used at frequent intervals.

### Tension Headache (Psychogenic Headache)

This headache of the nervous, tense and emotionally unstable individual is strictly psychosomatic. Its functional character should be explained to the patient, and appropriate psychotherapy given. A thorough investigation and examination and a sympathetic interview is very essential to get the patient to relinquish his fixation on organic disease and gain insight enough to admit his emotional conflicts. Sedation is helpful. Analgesics may give relief at times. Generally symptomatic therapy is valueless and often may be harmful. Cafergone (E. C. 110) has helped in some cases reported.

### Migraine

Prevention: To reduce the frequency of attacks the patient should avoid nervous and emotional strain. Eyestrain should be corrected with properly fitted glasses and avoidance of work that puts undue strain upon the eyes. The patient should avoid foods to which he may have a sensitivity, and maintain a good regularity of exercise, rest, sleep and bowel habit. Ascorbic

acid has a mild vasoconstrictor effect and may be taken in 100 mg. doses three times a day. Ligation or periarterial infiltration of the artery in the region of the headache is recommended where vascular disease and the like do not allow specific treatment of the attack. Other measures are the correction of any deficiencies, abolition of anemia, giving thyroid for low metabolism, reducing menopausal symptoms by the judicious use of estrogens, nicotinic acid, sedation, and antihistaminic drugs. Histamine desensitization has been helpful in a large percentage of cases, especially the atypical cases<sup>1</sup>, but should not be given to patients with peptic ulcer, renal or vascular disease<sup>1,2,3,4</sup>.

In Attack: Ergotamine tartrate (Gyn-ergen) is the most effective weapon in the attack and may be given intramuscularly or intravenously, 0.25 to 0.5 mg. or orally 4 to 5 mg. at onset, followed by 2 mg. hourly until relieved or a total of 10 mg. is taken. The patient should be tested for sensitivity first. Cafergone tablets containing 1 mg. ergotamine tartrate and 100 mg. caffeine may be given orally starting with 2 tablets and giving one tablet every half hour until relieved or a total of 6 tablets taken. Suppositories of 2 mg. ergotamine tartrate, 0.25 mg. bellafoline substance and 100 mg. caffeine may be used giving one at first, repeating every  $\frac{1}{2}$  hour until a total of 3 are used. Dihydroergotamine methanesulfonate (D. H. E. 45) is not quite as effective as ergotamine tartrate but is less toxic and has less side reaction. It is given intramuscularly or intravenously, 0.5 to 2.0 mg. After giving these preparations the patient should take an appropriate sedative and lie down in a quiet dark room, and if possible sleep for an hour or so. Ergot preparations are contraindicated in pregnancy, hypertension, marked arteriosclerosis, coronary disease, peripheral vascular disorders and hepatic dysfunction.

Octin hydrochloride can be used safely during pregnancy, does not increase dysmenorrhea when given just before the menses, and does not produce nausea or vomiting. However moderate to marked elevations of blood pressure occur in

about 30 per cent of the patients. Tests may be made by giving 50 mg. intramuscularly and taking the blood pressure every 10 minutes. If there is no rise in blood pressure in 20 minutes another 50 mg. dose is given and the blood pressure determinations continued. If there is still no increase (or less than 20 mm of mercury systolic and 10mm diastolic) the patient may take 75 mg. at onset of headache and if in an hour is not completely relieved, may take 25 mg. more. If a moderate rise of blood pressure (20 to 30 mm systolic and 10 to 20 mm diastolic) ensues the patient will take only 50 mg. initially and no second dose. If greater rises in blood pressure occur, Octin should not be used<sup>4</sup>. Octin mucate is seldom useful by mouth.

Few patients are benefited by dihydroergocornine (DHO-180) orally or hypodermically. Oral ergonovine seems to be more effective than oral ergotamine, possibly because it is more soluble.

Octin-Dihydroergotamine mixtures of 50 mg. Octin and 1 mg. DHE 45 frequently will help in cases that develop excessive hypertension on 100 mg. Octin and who derive no benefit from DHE 45 alone<sup>4</sup>.

Oxygen inhalations are helpful in some cases if used early. Likewise aspirin, aspirin and seconal, and codeine phosphate are sometimes helpful early. No opiates should ever be left in the hands of a patient.

### Histamine Headache

Specific allergens should be eliminated. Elimination diets, if used, should be thorough. Octin is frequently effective. Temporary relief may be obtained by assuming the erect posture or compressing the carotid artery. Intravenous epinephrine (0.1cc of 1:100,000 dilution, used cautiously in hypertension or hyperthyroidism) may help. Benadryl is reported to reduce histamine edema and give prompt relief in histamine and tension headaches with oral doses of 50 to 500 mg. daily, or intravenously 10 to 120 mg. (60 mg. in 100cc normal saline) given by drip in 10 minutes. Pyribenzamine orally 25-50 mg. every 4 hours has the same action with fewer side reactions<sup>5</sup>. MacNeal finds no results with antihistaminics<sup>4</sup>.

The most practical treatment is histamine desensitization and may be done subcutaneously, intravenously, or a combination of the two. The former method appears to give better results. Subcutaneously a solution of 0.275 mg. histamine

diphosphate per cc is administered twice daily, beginning with 0.1cc and adding 0.05cc to each succeeding dose. It is never necessary to go above 1cc. If there is slight flushing or other reaction, the next dose should be cut 50% and go on as before. After the attacks have disappeared sometimes it is necessary to administer a maintenance dose for an indefinite period. Intravenously 2.75 mg. histamine diphosphate with 1 gram ascorbic acid in 250, 500 or 1000cc in isotonic sodium chloride solution is administered 12 to 30 drops per minute depending on tolerance for a period of 1½ hours daily until markedly improved or headache free. This averages 2 weeks. During the intravenous treatment the patient should sip milk or am-phojel, and have food in the stomach<sup>6</sup>. The patient tolerates 10 times more histamine base intravenously than he does subcutaneously<sup>1</sup>. Authorities vary on the details of these methods <sup>1,2,3,4,6,7</sup>.

Kendall's adrenocortical extract has caused the attacks to disappear.

### Vasodilator Headache

These "atypical migraines" of Horton respond well to intravenous histamine. Psychotherapy is of little value as they are not the result of anxiety, nervous strain or psychosomatic disturbance.

### Psychic Headache

"Fear of brain tumor, stroke or insanity causes attention to the head. Attention causes fear, and fear causes headache which is more of a terrifying sensation than a headache. Treatment consists in sufficient neurological examination to satisfy the patient that he does not have the feared disease.

### Traction or Intracranial Headache

Drainage Headache: The spinal puncture headache does not occur commonly in patients allowed to be up and about after the spinal tap, but is common in those kept flat in bed several hours<sup>8</sup>. A small caliber needle with bevel turned laterally prevents cutting as many of the longitudinal fibers and prevents leakage. Acetylsalicylic acid 650 mg. (10 grains) and phenobarbital 65 mg. (1 grain) are the standard treatment. Octin, orally, 130 mg. (2 grains) and may be repeated in one hour. Octin can be combined with aspirin and phenobarbital. Finally codeine is permissible if these fail.

Brain Tumor Headache is for the neuro-



surgeon. Some analgesic treatment may be tried until in his hands. Intravenous 50% sucrose may be helpful.

**Late Posttraumatic Headache:** There is a psychic factor in these, especially if compensation is involved. Their treatment includes adjustment of all emotional factors, financial as well as domestic. For the few that develop true cerebral atrophy there is no treatment, and they usually are fatal.

The headache of subarachnoid hemorrhage usually abates a few days after the hemorrhage stops.

In headache of sinus thrombosis the treatment is directed to the underlying condition. There is no contraindication to the liberal use of salicylates, codeine, Demerol, etc.

#### **Extracranial Headache**

These are managed by analgesics and correction of the primary defect in the eyes, ears, nose, paranasal sinuses or teeth.

The pain of superficial arteritis can sometimes be greatly diminished by excision of a segment of the involved artery. Temporal arteritis frequently is a cranial arteritis.

Tic douloureux may be relieved with antihistaminic drugs.

In all of these headaches the psychogenic factor may be of primary or minimal importance.

Neuralgias of the posterior scalp, neck and face may be treated symptomatically by heat, aspirin, codeine and nicotinic acid (100 mg. t. i. d.). Cocainization of the sphenopalatine ganglion usually gives effective relief from neuralgia of this particular nerve. Injection of large amounts of thiamine hydrochloride (50 mg. daily) has given complete relief in many cases. Opiate addiction is to be avoided.

#### **Intracranial and Extracranial Headache**

These are due to both traction and direct nerve irritation.

Early posttraumatic headache is mostly extracranial and is a pain rather than a headache. It is usually of short duration unless painful scars develop in the scalp. These scars may be removed surgically or relieved by avulsion of the nerve.

The headache of intracranial inflammations (meningitis, encephalitis, brain abscess or poliomyelitis) is mostly intracranial. Here we treat the primary disease.

Headache due to cerebrovascular accident is not usually a problem as unconsciousness intervenes so promptly. Salicylates, caffeine and codeine are helpful. Opiates depress the respiration and should be avoided.

#### **Headache of Acute Infections**

Treat the underlying illness. The pain may be controlled by salicylates, fortified with codeine if necessary.

#### **Hypertensive Headache**

Symptomatic relief is obtained with a combination of aspirin, codeine and secional. Phenobarbital or amytol may be used. Bed rest and quiet in gaining relaxation is helpful. Ergotamine tartrate is effective but should be used with caution due to its vasoconstricting effect. Cafergone (1 mg. ergotamine tartrate and 100 mg. caffeine citrate) is sometimes useful, and probably is safe if used only occasionally. Octin should be avoided.

Preventive therapy is psychotherapy and sympathectomy. While potassium thiocyanate is helpful, it should not be used if significant renal impairment has occurred.

#### **Headache of Arteriosclerosis**

The specific treatment here is nicotinic acid 50 mg. with acetylsalicylic acid 0.3 grams (5 grains), and may be repeated in 2 hours.

#### **Headache of Sunstroke**

Prompt reduction in the body temperature by cold water helps the headache as well as the general condition. In extreme case cold intravenous normal saline and cold enemas are helpful. Salicylates and codeine serve as analgesics and antipyretics.

#### **Menopausal Headache**

The treatment of a true migraine can usually relieve the menopausal headache. And it is usually prevented by the administration of appropriate amounts of estrogenic substances orally. Parenteral injections appear to give no better help here. Start with 1.25 mg. of natural conjugated estrogenic substance daily for one month. Then gradually reduce the amount at 3 or 4 week intervals until it can be discontinued. It should not be given in patients with cancer or precancerous lesions, or with a strong family history of cancer.

### Failure in Treatment of Headache

The greatest reason for failure in the treatment is incorrect diagnosis. At times there are multiple causes which have not been recognized. Sometimes medication is not given early enough or not in adequate dosage. Then there may be some emotional stress added because of being disabled by the headache and inconvenienced physically and financially by the therapy. Finally there may be a residual muscle spasm following a severe headache which is a source of pain in itself.

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## POST MENOPAUSAL BLEEDING FROM BENIGN LESIONS OF THE GENITAL ORGANS

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The purpose of this paper is to offer some suggestions for the management of post menopause patients who are bleeding from a benign lesion of the genital organs. Some of the treatments for these benign lesions are presented and the methods used to differentiate between the benign and early malignant diseases are discussed. The incidence of benign lesions varies according to the source of statistical study and depends upon how well patients are screened. For instance, those hospitals and clinics designated for treatment of cancer will report about 65 per cent of their cases of post menopause bleeding as having cancer. The general hospitals will report about 50 per cent cancer while the physicians limiting their practice to gynecology will find a malignancy in about 30 per cent of their cases. In general practice there will be even fewer cancers and a proportional greater number of benign lesions. Moreover most of these cancers will be obvious and immediately transferred to a specialist for treatment. This leaves, for the general practitioner, the management of a large group of post menopause patients with benign, or at least not obviously malignant disease.

In order to have material for a study of the management of such patients, an analysis was made of 100 consecutive

private cases in which vaginal bleeding had occurred at least one year past the menopause.

### Analysis of 100 Cases

To obtain the 100 cases it was necessary to review 196 records of post menopause gynecological cases. It would seem by this that there is about a fifty fifty chance that the post menopause patient who complains of female trouble will give bleeding as a symptom. It is interesting to note that in the group of the 96 patients, who had had no bleeding, there were only four cancers found. There was one cancer of the clitoris, one of vulva, one of vaginal wall and one of the ovary. It is also of note that there were no cancers of the cervix or fundus in this non bleeding group. There were two cases of severe senile vaginitis and two cases with a large cervical polyp in which bleeding probably occurred but was not given as a symptom.

### Percentage of Bleeding

In the group of 100 cases of bleeding there were 20 epidermoid carcinomas of the cervix, 3 adeno-carcinomas of the fundus, one sarcoma of the uterus, and one primary cancer of the vaginal wall. There were three cases in which a diagnosis was not made because the patient did not submit to biopsy or did not return for proper evaluation. There were two patients who were mistaken about



the source of bleeding. One of these had bleeding hemorrhoids and the other had a severe cystitis. This leaves 70 cases out of the 100 selected in which a benign lesion was found to be the cause of bleeding. A detailed analysis of these 70 cases is presented for the purpose of discussion of some of the diagnostic and treatment problems.

### Lesions of the Vulva

There were six benign lesions of the vulva; two of monilia, one of leukoplakia kraurosis, one of combined monilia and kraurosis, one of post-radiation telangiectasis and one of fissure associated with atrophic vulva-vaginitis. None of these presented any particular diagnostic problem.

Monilia usually responds to treatments with a 2 per cent aqueous solution of gentian violet or self application of Procion Gel or Naprylate provided the vagina as well as the vulva is treated. Gentian violet should not be applied oftener than once every five days. The urine should always be tested for sugar.

Kraurosis of the vulva may be treated with large doses of Vitamin A, B, and C and estrogen cream. If improvement does not follow a vulvectomy is usually advised. These patients should be seen at frequent and regular intervals in order to detect any early malignant change. Inasmuch as monilia and kraurosis of the vulva are sometimes associated, a few applications of gentian violet to kraurosis of the vulva will often bring surprisingly good results.

Fissures are usually found associated with degenerative and non specific lesion of the vulva. We have all seen the obese old women with an open vagina, a little stress incontinence and marked senile changes who have fissures. The treatment is directed to the causative factors as well as to the bleeding fissure.

### Vaginal Wall

There were 22 lesions of the vaginal wall, seven of senile vaginitis, three of trichomonas vaginitis, four of ulcers due to prolapse, three of ulcers due to pessaries and one of ulcers due to a chemical. There were two cases of fissures as a result of previous radiation.

Senile, or atrophic vaginitis, respond about 100 per cent to large doses (100,000 units a day) of Vitamin A and daily ap-

plications of estrogen cream. Post radiation vaginitis and fissures are treated the same way.

The case of chemical vaginitis was caused by undissolved potassium permanganate crystals used in a douche. There were several kissing bleeding ulcers with a dark base. The Kahn was negative and the biopsy showed only chronic inflammation. No treatment was needed.

Ulcers due to prolapse or pessaries are treated by plastic surgery as soon as the vaginal mucosa is brought into a more or less healthy condition by the use of Vitamin A, estrogen, bed rest and perhaps small doses of thyroid.

In treating trichomonas vaginitis after the menopause, large doses of Vitamin A in addition to the usual antiseptics are of some help.

All localized lesions and ulcers should have a biopsy even though etiology seems obvious unless the lesions respond rapidly and completely to treatment.

### Cervix

There were 22 benign cervical lesions; eight of chronic cervicitis, seven polypi, two of small cervical fibroids and two of fissures. Cervicitis, polyps, fibroids and fissures of the cervix can all be treated by biopsy and deep cauterization or conization. There were two cases in which there was delayed healing following cauterization. No further treatment was needed but a repeat biopsy was taken.

### Fundus Bleeding

Fundus bleeding from the fundus (endometrium) was present in 20 or about 30 per cent of the cases. The breakdown on these is as follows: one hyperplasia of the endometrium of unknown etiology, one hyperplasia associated with a granulosa cell tumor of the ovary, two submucous fibroids, two submucous endometrial polyps, one of the endometritis, two pyometria of unknown etiology. There were nine cases of bleeding associated with estrogen therapy. Five of these had a curettage all showing hyperplasia of the endometrium and the other three were treated by withdrawal of the hormone without curettage.

The treatment of benign lesions of the fundus depends upon several factors and varies with the attending surgeon. Polyps and small submucous fibroids can often be removed with a ring forcep or heavy clamp at which time a thorough curettage is done. However, if bleeding continues a

hysterectomy should be done. A hysterectomy should always be done if there is a large submucous tumor because the uterine cavity is usually so distorted that a satisfactory curettage can not be done. A cancer may be hidden behind or in the tumor. Non specific pyometria usually responds well to continuous drainage. Careful follow up and curettage should be done to search for cancer. Tbc of the uterus should be treated by radical surgery and streptomycin.

Uterine bleeding associated with estrogen therapy presents an ever increasing problem. If there is a consultant on the case a curettage will probably be advised. If a family physician is aware that his hormone therapy has precipitated the bleeding he will stop the hormones, do nothing, and be right at least 9 times out of 10. However, if this plan is followed and bleeding continues for more than 4 weeks a diagnostic curettage is imperative.

In the entire group there were two known instances in which the diagnosis was not complete. Both of these cases had been bleeding from severe senile vaginitis. One patient had been under treatment for three weeks when she changed to another physician who found a pyometrium. The other patient was treated for her senile vaginitis in July, 1948 and followed for six months with apparent cure. In July, 1949, a year later, a routine followup examination was made and no lesion found and there had been no bleeding. The following year the patient was again seen for follow up examination, at which time the patient stated that she had been bleeding for about six months. An adenocarcinoma of the fundus was found. In both of these cases simple probing of the uterus would probably have disclosed the hidden lesion.

### Discussion

Although this group of 70 cases represents 20 different causes for benign bleeding it does not furnish a complete list of benign lesions. It does, however, include most of the common ones. The following outline gives a more complete classification of benign lesions which may cause bleeding from the genital tract after the menopause:

### Lesions of the vulva, vagina, and cervix which may produce bleeding.

#### COMMON INFECTIONS:

- Monilia
- Trichomonas

Condylomata acuminata  
Non specific chronic cervicitis

#### UNCOMMON INFECTIONS:

- Tuberculosis
- Diphtheria
- Streptococcus or Staphylococcus vaginitis—associated with mechanical trauma use of strong medication.

#### VENEREAL DISEASE:

- Syphilis, granuloma inguinale
- Lymphopathia venereum

#### DERMATITIDES:

- Local—herpes simplex, herpes zoster
- Systemic—Pellagra

#### NEW GROWTHS:

- Polyps, cervical fibroids

#### DEGENERATIVE:

1. Senile or atrophic vaginitis
2. Leukoplakia kraurosis
3. Xanthoma

#### TRAUMATIC LESIONS:

- Ulcers—Prolapse or pessaries or chemicals
- Vaginitis—Radiation and chemical
- Fissures in healed scars of vagina or cervix
- Eversion and laceration of cervix

#### FUNDUS BLEEDINGS

- Tumors: Submucous fibroid, submucous polyps, adenomyosis  
endometrial cysts
- Hyperplasia: Therapeutic estrogens
- Ovarian tumors
- Etiology unknown—
- Endometritis: Non specific:  
Etiology unknown  
Following radiation or cautery  
Associated with severe vaginitis or cervicitis
- Specific Tuberculosis
- Systemic Diseases  
Blood dyscrasia  
Hypertension and arterial sclerosis  
Passive congestion  
cardiac failure  
pelvic tumors

### Differential Diagnosis and Management

There are certain general principles which if followed will aid in the differential diagnosis and management of the patients who are bleeding after the menopause.

1. When in doubt take a biopsy.
2. A probe should, when possible, be



passed into the uterine cavity. If there is bleeding the patient probably has a cancer and a diagnostic curettage should be done.

3. If any supposedly "benign" lesions do not show prompt and complete healing a biopsy should be made.
4. If bleeding does not stop completely within four weeks of withdrawal of estrogen a diagnostic curettage should be done.
5. If a hyperplastic endometrium is obtained when estrogen has not been given a tumor of the ovary should be suspected.
6. Radiation in any doses should not be used in post menopause bleeding unless there is cancer.
7. If bleeding recurs after one or two curettages even if no malignancy is found a hysterectomy should be done. This is not an unusual occurrence.
8. It is cancer until proven otherwise.

In closing, a few words may be said about this last statement of "Cancer until proven otherwise."

This idea has so permeated the minds of the layman that such a fatalistic attitude has developed that the elderly woman will often neglect to present herself for study, and simply resign herself to what she thinks is an inevitable death by cancer. It is this hopeless attitude, which in part, will prevent the patient from getting adequate treatment for her benign disease or early malignancy. It is important in our cancer educational program to emphasize not only that cancer is curable in its early stages but that bleeding does not necessarily mean cancer. By so doing it is quite possible that more patients will present themselves for care.

### DISCUSSION

**J. B. Stith, M. D.,** Louisville: We, undoubtedly, too often fail to emphasize the recognition and treatment of nonmalignant genital lesions in the post menopause which are causing bleeding. Dr. Barrett's essay stresses the importance of recognizing malignant disease yet there is some attempt to buffer the all-out attack against malignant disease at the expense of failure in recognizing and treating benign genital lesions. We would like to

stress that one of the most important symptomatic treatments in the post menopausal bleeders is relieving the patient's fear of cancer. In order to give this advice safely one must carefully exclude malignant lesions, as has been pointed out. We might add that when the cause of the bleeding is not found in the lower genital tract and dilatation and curettage is necessary a preliminary pelvic examination under anesthesia should be routine. This procedure is especially helpful in obese individuals and in those with vaginal atrophy.

In a good number of these older individuals who have their endometrium examined there is a microscopic picture found which resembles the endometrial hyperplasia of the younger individual. Novak reported this condition in 50% of 139 specimens examined. Speert (SGO 89 Nov. 1949, 551-559) found endometrial hyperplasia in only 3 specimens out of 60 examined and these three specimens were from individuals who had received estrogen. Speert contends that true endometrial hyperplasia does not exist except in the presence of estrogen. Novak proposes that there is some source of estrogen other than the ovary in these post menopausal patients. Novak designates a good proportion of the hyperplastic endometriums as "retrogressive hyperplasia." This Speert believes corresponds to what he found in 70% of the 60 post menopausal specimens examined, i. e., large and small cysts in the endometrium which he calls retention cysts due to shrinkage and occlusion of endometrial gland openings. Speert gives as further evidence that these endometriums are not true hyperplasias the fact that the coiled arterioles, which are present under the influence of estrogen, are not found. He points out that the rupture of thin wall vessels which are close to the surface is the cause for bleeding.

Novak also points out a definite relationship between post menopausal endometrial hyperplasia and adenocarcinoma of the endometrium as he has seen both lesions in the same specimen. Others, notably TeLende, are not impressed with this relationship.

In view of these differences we probably can feel more secure in not actively treating these cases reported as endometrial hyperplasia after the menopause when no palpable ovarian tumor is present and when active cell proliferation is not present in the endometrium. Occasionally though, one feels justified in doing a laparotomy on these cases to make or rule out a diagnosis of malignant disease.

## TRENDS AND OPPORTUNITIES IN INDUSTRIAL MEDICINE.

Edward C. Holmblad, M. D., F. A. C. S.

CHICAGO

It is a real honor and a privilege to take part in the 1950 meeting of the Kentucky State Medical Association, not only because of the numerous friends I have among you, but also because my subject indicates the growing importance of industrial development in Kentucky.

The field of industrial medicine and surgery is not as new as many believe, although it has reached its real growth and development in the past 30 to 40 years. Even Aristotle described a diet for gladiators; Plato studied posture of artisans; Pliny studied sulphur and zinc exposures and designed the first respirator or protective mask, while Hippocrates in the 4th century B. C. recognized the toxicity of lead. We recognize Ramazzini as the father of industrial medicine because he published his masterpiece on the subject in 1700.

Since 1870 we notice the important part of the railroad surgeons in the development of this field. Not only did they have to become proficient in the treatment of injuries but they were also called upon to examine and certify as to the physical fitness of operating employees, engineers, firemen, brakemen, flagmen, conductors, dispatchers, and others.

The workmen's compensation acts, the Federal Employer Liability and the Longshoreman Acts have aided in the development of industrial surgery and, more recently, in the development of industrial medicine by considering occupational diseases and exposures for compensation.

Industrial Medicine and Surgery demands that in addition to being well qualified, physicians and surgeons must have the additional knowledge, judgment and experience in the industrial field.

### Relationship to Other Specialties

The relationship of Industrial Medicine to all the other specialties has a similarity to that of the specialty of Pediatrics. The pediatrician consults with the surgeon, cardiologist, radiologist, urologist, oph-

thalmologist, neurologist, etc. in the care of a child from birth up to 15 or 16 years of age. The industrial physician, then, has a similar relationship with all the specialties in the care of the injuries and health of the employed worker during his life span of employment. It is necessary that the specialist consulting or treating such an employee have this industrial relationship in mind. For instance, the cardiologist must evaluate the relationship of an accident, or an alleged accident, to the cardiac lesion and condition. The radiologist must state definitely the relationship of the X-ray findings to the accident. To do this he has learned the advantage of taking control exposures of the corresponding part of the opposite extremity, or he may have to take oblique or special views of the skull or spine to satisfy himself about the relationship to an accident. The gynecologist when examining an industrial accident patient must be able to give an opinion on the relationship of the accident to the retroverted uterus, procidentia, or pathology of the adnexa. All specialties have a similar industrial medical viewpoint to their specific specialty problem.

### Trend of Medical Service

The trend of industrial medical service has been to increase the quality and the value of such service to the employee by the establishment of a comprehensive medical department with experienced, qualified industrial physicians and surgeons.

In practically all instances, such medical departments render treatment only for work connected injuries, occupational diseases and emergency care only to non-plant illnesses, that may occur while the employee is at work. On the other hand, the medical department is responsible for a great many referrals to family physicians. I am sure the family physicians owe a debt of gratitude to the plant physicians referring menopausal problems, hypertension, chest, heart and many other conditions urging medical treatment.

During the past year I have had oc-



casion to see four cases of acute appendicitis that developed in employees while at work. In all instances I promptly referred these patients to their family physicians, by whom they were promptly operated. One of these cases was the source of real personal gratification. An employee whom I knew came into the medical department at 2:30 p.m. with abdominal pain and tenderness, positive cough reflex, and a leucocyte count of 14,000. He insisted it was only a slight upset stomach, wanted to be sent home, and said he would see his doctor the following day. When I suggested I phone his doctor he said the doctor left his office at 3:00 p.m. and he didn't want to bother him. This was all the more reason to call him promptly. When I explained the findings to the doctor he agreed to meet the patient at the hospital. I sent the patient directly to the hospital, where a gangrenous appendix was removed about 6:00 p.m. that evening. This patient was back at his desk working 16 days later. Our medical department not only rendered a service to this patient, but also to the family physician, and to the company by whom he was employed.

So many times employees returning to work after operations, sore throats, virus pneumonia, and other conditions, express their appreciation for the fact we referred them to their family physicians early.

#### Opportunities for Service

There are wonderful opportunities to render service in this field of industrial medicine. Early diagnoses and accurate diagnoses are imperative. In cases of accidents, X-rays are not only taken promptly but in many views and of adjacent parts. It was the industrial surgeons who pioneered in rehabilitative physical therapy treatment. Massage, active and passive motion, whirlpool baths, and regular programs for muscle strengthening exercise and loosening up of joints were established in industrial physicians' offices long before they were available in our hospitals. Walking irons for lower leg and ankle fractures were used extensively in industrial practice before coming into general use. Likewise, early ambulation in cases of hernia operation and many other types of operations were advocated by industrial surgeons.

There is another phase of the industrial physician's and surgeon's duties that

is a real challenge to any physician. That is the problem of early, prompt and efficient medical service. When an accident happens to one of your employees, it is up to you to see that everything that is possible be done to render the best possible care. You get up and go down to the hospital and examine and see the fractured leg. You don't just tell the interne or the resident to give first aid and that you will see the patient some time the next morning. This first few hours after an accident is an ideal time to gain the confidence of the patient and his family. Your company officials will appreciate your special efforts to render good service.

The industrial physician is always being checked up on his work by the union, the fellow workers, friends, the employer, and the insurance company. His work has got to stand the test of these check-ups. In industrial practice the art and tact of handling patients is developed to a high degree. Industrial patients will not wait any length of time in the waiting room. They expect to be cared for immediately. They are sometimes surly and unreasonable, and it takes a great amount of tact and ability to handle such cases satisfactorily. The art of examining a malingerer or an exaggerator would be a chapter by itself.

#### Opportunities Available

Now let us consider some further challenges or opportunities in the field of Industrial Medicine. I would say that one of the greatest opportunities is the challenge of keeping your employees physically and mentally well by all means to the best of your ability. It is a great satisfaction to do this job well. The gratitude of employees many times expressed as a real esteem is only a part of one's remuneration. A plant surgeon friend of mine was recently transferred to the executive medical officer's position and his work became largely administrative. On a return visit to the city and plant where he had treated their employees for many years he was thrilled and had his heart warmed by the greetings and expressions of gratitude from these employees. It was an achievement of satisfaction difficult to evaluate and that cannot be evaluated in dollars and cents.

The pre-employment or job placement examination can be made very valuable to

the employee. It is your responsibility to know what job best fits the individual's physical condition and see that he gets it. You can point out physical defects without offending him, you can do a careful, competent examination and finish by saying, "I believe you will be a very fine employee. I hope you like your work here." Such simple thoughtfulness creates confidence and respect for the medical department.

The periodic health examination of employees, key personnel and executives offers a real challenge to any medical department. It is gratifying to notice that certain clinics, internists, and the general medical profession are becoming interested in doing periodic health examinations. It is a real pleasure to see well and healthy patients part of the time instead of always seeing sick patients in pain, misery, suffering and complaining.

To keep employees, supervisors, and executives mentally well, contented and happy ties in closely with all the problems of psychosomatic medicine, and this can be discussed to any desired length.

#### **Qualifications of Medical Director**

The medical director, chief surgeon, or head of an industrial medical department has to be an experienced and capable department head. He is like the coach or captain of a team. He usually hires, trains, and supervises the work of the members of his team and evaluates their work and the value of the medical department service. On his team are industrial plant physicians and surgeons, consulting physicians and surgeons, industrial nurses, hygienists, laboratory and X-ray technicians, staff office workers, safety engineers, safety directors, and sometimes employment personnel. It is a real challenge and satisfaction to head up and administrate the smooth operation of such a medical service.

#### **Public Relations**

Another real opportunity for Industrial Medicine is to be a valuable public relations contact between the medical profession and the employed workers. Each contact with an industrial worker by the medical department can be made a favorable contact for our present American type of medical service and get credit for the vast medical advances made under that system of medicine. We can easily

and readily convince our employees that the voluntary method of hospitalization and insurance for medical care far excels any type of compulsory health insurance or socialized medicine.

I have had a couple of experiences that illustrate what happens under government controlled hospitalization and medical care. About a year ago one of our employees asked to be excused at noon on Tuesday as he was going to one of the Veterans' Hospitals that afternoon to have his tonsils removed. Permission was granted and we expected him back to work in a week or so. The following Tuesday, a week later, he telephoned me from that Veterans' Hospital stating that he had been around the hospital for a whole week and they hadn't gotten around to doing his tonsillectomy. Seven full days of wasted hospitalization, loss of working time, loss of an employee to the company, and at your and my tax expense!

#### **Case Report**

A second illustrative simple case came to my attention while on my trip to Hawaii last November. A veteran caught the tip of his middle finger in the door of his automobile, losing only the very distal part of terminal phalanx. Now, in industrial practice, such a case could be treated in the plant medical dispensary or as an in-and-out ambulatory patient of the hospital if a whole thickness protective skin transplant was to be applied. In either event, a light job could be found for such an employee and little or no time lost from work. In the case of the Hawaiian veteran, he was a patient in Tripler General Hospital on Oahu, Hawaii, for six weeks. Think of it—a hospital patient for six weeks with a simple, uncomplicated traumatic amputation of the tip of his finger! You can find any number of such unreasonable periods of hospitalization and ridiculous medical care under government supervision. When employees realize that they will be called upon to pay the expenses of compulsory health insurance, then socialized medicine can never be forced on the American people. If we all render a high grade medical service, we have a right to get full credit for such service rendered and see that our present system of practice of medicine in the United States is not taken away from us.

#### **New Trends**

Now, briefly, to mention a few further trends in Industrial Medicine. There are



some definite indications of greater service. There is going to be greater stress laid on industrial hygiene, or "environmental hygiene" as it is now called, in providing better workshops. Toxic exposure and industrial hazards are being eliminated or the exposure reduced to a minimum. The smaller industrial plants will have to follow the lead of larger industries in providing such improved workshops.

Industrial physicians and surgeons now have had much better medical and hospital training than those of 20 to 30 years

ago. Higher qualified and trained medical men are accepting medical directorships of plant medical departments. Better medical departments are being furnished by industry and better salaries are being paid to all medical department personnel, including plant physicians as well as medical directors.

Industrial Medicine has become recognized as a real challenge to the physicians and surgeons, because it demands the best possible medical and surgical service for the workers in industry.

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## THE X-RAY EXAMINATION OF THE SPINE

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The purpose of this paper is to aid the rural physician in the X-ray examination of the spine by outlining the technique of the X-ray examinations according to the clinical signs and symptoms, by developing a systematic method of examining the roentgenograms and by discussion of the significance of the common abnormalities noted on the film.

A proper type of X-ray examination must be tailor-made according to the clinical possibilities just as any other type of laboratory or clinical examination must be performed according to the dictates of the clinical situation.

Most X-ray examinations of the spine are made with the endeavor of seeking a bony injury or the cause of back discomfort or disability. Diagnostic Roentgenology has now passed out of the days of "A-P and lateral" film technique. A complete examination of most portions of the spine requires additional studies. When one considers that the welfare of the patient and the reputation of one or more physicians is at stake on nearly every X-ray examination, the cost of a few additional film studies is a rather insignificant factor. The average confident physician is not content to palpate the abdomen in one or two locations or listen to the chest in one or two areas. In a similar fashion "A-P and lateral" roentgenograms do not always tell the entire story.

### Roentgen Procedures Cervical Spine

Antero-posterior and lateral projections of the cervical spine may suffice only when looking for gross fracture or dislocation in an obviously seriously injured patient. If no gross disorder is found, and the patient's condition permits, then open mouth projections for the upper cervical segments and oblique views for the foramina and articular processes may be indicated. In any study of the cervical spine in an attempt to discover the cause of pain in the neck, shoulder, or arms, oblique studies which demonstrate the intervertebral foramina are necessary. An open mouth projection of the odontoid is important in most examinations and certainly where complaints of occipital headaches or pain in the upper cervical region is present. The technique for all positions will not be discussed as most standard references on X-ray technique demonstrate these well.

### Dorsal Spine

Antero-posterior and lateral studies of the dorsal spine will suffice for most examinations if the films are of satisfactory diagnostic technique. Special oblique views may be necessary in order to examine the bodies of the upper three or four dorsal segments. When one sees a suspicious deviation from the normal, antero-posterior, lateral and possibly oblique spot views, centered at this level, may give additional information.

## **Lumbar Spine**

Simple antero-posterior and lateral projections of the lumbar spine may suffice when seeking gross fracture or dislocation only. When one clinically suspects the possibility of a fracture in the lumbar region the film study should include the lower half of the dorsal spine as frequently fractures in this region are missed on films which include only the lumbar spine and pelvis. It must be remembered that in most injuries of the spine the pain is nearly always referred to a level lower than that of the actually injured segment. Fracture of the lumbar spine should be suspected where there is a fracture of the os calcis due to a fall upon the feet.

Inasmuch as the lower lumbar and lumbo-sacral region is the most common source of backache a rather comprehensive examination of this region is necessary. The oblique studies are necessary to demonstrate the apophyseal joints and the articular processes which are frequently a source of pain and which are not well viewed in the routine antero-posterior and lateral studies.

## **Lumbo-Sacral Region and Pelvis**

The lumbo-sacral, sacro-iliac and hip joints regions may be grouped together in a single pathological unit as frequently a disorder in any of these regions may produce confusing referred pain. The lumbo-sacral region is best examined by small spot lateral projections and antero-posterior projections with the tube angled approximately 30 degrees toward the head. This region is not usually well visualized on large films which include the entire lumbar spine and pelvis. The sacro-iliac joints are brought out well in the postero-anterior projection and the oblique study for the lumbar spine demonstrates these regions well. The pelvis is usually best studied on a single antero-posterior projection including this area only. Standing lateral films will sometimes demonstrate a spondylolisthesis when the actual subluxation may not be noted on the supine film. The hip joints should be well visualized on the films of the pelvis as occasionally hip joint disorders may cause a disturbance in spine mechanics with resultant back pain. Standing antero-posterior films of the pelvis with weight bearing on one leg at a time, may demonstrate subluxation of the sacro-iliac joints where a severe injury to the pelvis has occurred; there will be a no-

ticeable elevation of the pubis, at the symphysis, on the involved side.

## **Systematic Study of Roentgenograms of the Spine**

### **Posture and Alignment**

The normal spine usually presents rather consistent curvatures in various regions. In most instances the spine should be entirely straight in the antero-posterior projection but frequently one sees very small scolioses which are usually of no significance. The lateral projections should demonstrate a normal cervical lordosis, a mild dorsal kyphosis and a normal lumbar lordosis. Alteration, straightening or reversal of these curves usually indicates muscle spasm which may be secondary to muscular or ligamentous injury, bony injury or dislocation, bone or joint infection or adjacent soft tissue infection.

### **Cervical Spine**

The cervical lordosis is usually quite pronounced and straightening or reversal of this curve following an injury renders a careful examination for bony injury important. Tuberculosis or other infection of the cervical spine, herniation of the cervical intervertebral disc, or osteoarthritis of the cervical apophyseal joints may all produce a loss of the cervical lordosis. Fractures and dislocations frequently produce an obvious deformity in the cervical curve.

### **Dorsal Spine**

Straightening or loss of the normal thoracic kyphosis is a rather infrequent finding and is usually seen early in rheumatoid spondylitis. The kyphosis, when increased, is usually secondary to deformity of the bodies caused by osteochondritis in adolescence and by minimal compression deformities secondary to senile demineralization. A sharply localized kyphosis should suggest the possibility of Pott's disease and the destructive process involving a vertebra should be looked for. Severe compression fractures, particularly with displacement, will produce an obvious kyphus.

### **Lumbar Spine**

Usually there is a definite but mild lumbar lordosis which begins in the lower dorsal region and extends down and onto the sacrum. This curve is usually lost because of muscle spasm secondary to mus-



cular or ligamentous injury. Muscle spasm secondary to a herniated intervertebral disc, bony injury or bone infection will all produce straightening of the lumbar lordosis. One sees an increased lordotic curve in this region in spondylolisthesis and in increased and unstable lumbosacral angles.

### **Bone Density and Texture**

With a little experience one soon learns to evaluate the normal bone density and texture and detect abnormal changes. Generalized increase in bone density is a rare finding and usually seen in flourine or phosphorous poisoning and in Albers-Schonberg's disease. Localized areas of increased bone density, usually involving the bodies of the vertebra, most commonly suggest the presence of osteoblastic metastases or localized bone lymphoma. Infection such as typhoid or Brucellosis will occasionally produce increased bone density as will a few other chronic low grade infections. Increased bone density is frequently seen adjacent to disordered intervertebral spaces and apophyseal joints and suggests long standing bone reaction secondary to undue stress and strain. One may be lead to the diagnosis of a mild compression fracture due to increased bone density of the compressed cancellous bone in the injured body of the vertebra.

Generalized demineralization or loss of the normal bone density is a more common finding. This is most frequently seen in senile demineralization and when seen in a younger individual the possibility of a parathyroid adenoma should be considered. Localized areas of decreased bone density are most frequently due to bone destruction by infection or tumor. One must learn to differentiate between loss of density due to actual bone destruction and that due to simple loss of bone minerals without alteration in the bone texture and supporting architecture. Hemangiomas frequently involve the bodies of the vertebrae and produce severe demineralization and loss of the normal texture. Here one frequently sees coarse vertical striations which give a clue to a diagnosis. Giant cell tumors frequently involve the posterior arches of the vertebra and may produce loss of bone substance and demineralization producing a "soap bubble" effect.

### **The Vertebral Bodies and Intervertebral Spaces**

After quickly evaluating the alignment and bone density and texture of the spine

one should next carefully scrutinize the bodies of the vertebra and their adjacent intervertebral spaces. The bodies of the vertebra in the adult are ordinarily projected as a rectangle in the lateral, anteroposterior and oblique studies.

The bodies of the vertebrae in the young are normally slightly wedge shaped before the development of the bony epiphyseal plates. The anterior diameter of the body is less than the posterior diameter. One frequently sees a distinct notching in the anterior margin of the vertebra which marks the entrance of the nutrient vessels. This notching usually disappears in adolescence but is frequently carried over into the adult stage.

Ossification of the superior and inferior epiphyseal plates of the vertebrae usually takes place in an orderly and symmetrical fashion and usually there is complete union with the body. However, occasionally one of these secondary centers of ossification may not unite with the body and a small separate particle of bone will be visualized on the anterior and superior margins of the body of the vertebra; this must not be mistaken for a small chip fracture.

The bodies of the vertebrae may present three distinct variations from the normal. The most common of these is the wedging compression deformity in which the anterior height of the body is less than the posterior. In older individuals one frequently sees bony proliferation into the various ligaments attaching to the inferior and superior margins of the bodies. This produces bony lipping about these margins and may give a concave appearance to the anterior portion of the bodies. One occasionally sees concave depressions in the superior or inferior surface of the bodies and this usually represents herniation of the disc substance through the epiphyseal plates. This may occur in adolescence as a complication of osteochondritis or in the adult as a complication of severe demineralization. These concave depressions are usually of no clinical significance when seen in the healthy young adult.

The wedging deformities may be the result of compression fracture or bone destruction secondary to infection or tumor. Juvenile osteochondritis of the spine is a very common cause of symmetrical wedging of the vertebra in the lower dorsal region. Usually two or more adjacent vertebrae are involved and the wedging is usually at the expense of both the an-

terior and superior margins of the vertebra. Compression fractures almost invariably produce deformity at the expense of the antero-superior margin of the body only. Usually the plane of the inferior surface remains perpendicular to the posterior margin of the vertebra. In contradistinction the deformity of osteo-chondritis produces a symmetrically wedged vertebra. One must be very careful before diagnosing a symmetrically wedged vertebral body as a compression fracture.

This is a very rare occurrence and the diagnosis should be supported by good clinical signs and symptoms of a severe back injury.

The lipping and irregularity of the margins of the bodies due to bony proliferation into the ligamentous attachments is a common occurrence in the older age group and should not, per-se, be diagnosed as "arthritis." Any deformity of the body detected on the large survey films should be examined by means of small spot studies, made in several projections, localized at the specific level.

The width of the intervertebral spaces represents the amount of disc and cartilage substance present. Normally any one given space should have the approximate width of the spaces above or immediately below. Reduction of an intervertebral space suggests the loss of disc substance due to infection or herniation or secondary to chronic repeated trauma. The lumbo-sacral inter space is an important one and most difficult to evaluate. Where transitional or other anomalous vertebrae are present this disc is frequently narrow without clinical significance. On the other hand where there is an accompanying increased bone reaction at this level, or signs and symptoms of a herniated disc, a reduction of the inter space may be most significant. In the thoracic region one frequently sees an area of calcification in the intervertebral space. This is usually thought to be of no clinical significance. As a general rule infections will destroy the disc substance rather rapidly whereas the cartilage has great resistance to tumors and the intervertebral space may be well preserved where adjacent bodies have been completely destroyed by primary or secondary tumor deposit.

#### **Pedicles**

The pedicles are of importance in the X-ray examination mainly because they represent the lateral borders of the spinal canal and are well visualized in most pro-

jections. They are not well demonstrated in the cervical region but any antero-posterior projection of the dorsal or lumbar spine is considered of poor diagnostic quality. One should attempt to see the shadow of the pedicles for every vertebra in the particular examination performed. The complete absence of one or more pedicles or the abnormal widening of the interpedicular diameter may suggest the presence of a tumor or localized infection. The pedicles and posterior arches are not infrequently attacked by tuberculosis and giant cell tumors. Neurofibromas in the thoracic region are common intrathoracic tumors and almost invariably destroy one or more pedicles. Failure to visualize one or more pedicles may be the result of slight obliquity of the projection.

#### **Apophyseal Joints and Articular Facets**

The articular facets, apophyseal or intervertebral joints represent a most important but long neglected portion of the spine. These represent the only true diarthroidal or gliding joints in the vertebral column, other than the articulations about axis and atlas and the costo-vertebral joints. These joints have an articular cartilage, a synovial lining and articular capsule identical with the other movable joints of the extremities. These are, in all probability, affected by many of the disorders involving other arthroidal joints of the body. I personally believe that most true localized back pain is due to disease or other undue stress and strain involving these small articulations. They certainly demonstrate the changes of rheumatoid and osteo-arthritis identical with those seen in other joints similarly involved. Compression deformities and reduced intervertebral spaces probably produce their pain by throwing undue strain upon the capsules of these joints.

In the cervical region these articulations are fairly well demonstrated in both the lateral and oblique studies. Here one most commonly sees the post-traumatic form of osteo-arthritis. In the thoracic region these joints are rarely affected except by advanced rheumatoid-arthritis. In the lumbar region these joints are most important and are best visualized in the oblique studies, although occasionally they are seen fairly well in the antero-posterior projection. The most common disorder of these joints in the lumbar and lumbo-sacral region is the post-traumatic form of osteo-arthritis secondary to injured or unstable bony architecture which



throws undue strain upon these articulations. Here one sees reduced joint spaces, increased subchondral bone density and lipping about the margins of the joints. In advanced rheumatoid arthritis these joints may show varying degrees of cartilage destruction and ankylosis.

### **The Intervertebral Foramina**

The intervertebral foramina are not true bony canals except by virtue of the fact that two concave surfaces are opposed when two vertebral bodies are brought together. These foramina represent the site of emergence of the spinal nerves and a careful examination of these areas is indicated where one suspects referred or root pain. The demonstration of these foramina in the cervical region is most important where there is pain about the neck, shoulder or with radiation down the arm. Undue narrowing of these canals or encroachment upon their lumen by bony spurs may be most significant and should be sought for in these cases. In the cervical region the foramina are just adequate for the large nerves going to the brachial plexus. Undue narrowing plus soft tissue edema may produce nerve root pressure. In the thoracic region the nerves emerging through these canals are quite small and root pressure probably seldom occurs because of narrowing of the bony canals. In the lumbar regions the intervertebral foramina are quite large and root pressure due to bony prominence or bony narrowing probably rarely occurs. In attempting to evaluate the size and contour of the foramina it is best to have projections of both sides available for comparison.

### **The Posterior Arches, Spinus and Transverse Processes**

The posterior arch and its processes, except the articular, is not often involved in serious bone disease. Fractures of the transverse processes in the lumbar region may occur with direct trauma or serious muscular sprain. Rarely the spinus processes of the sixth and seventh cervical vertebra may be fractured by the prolonged use of long handled shovels. This has been called a "shovelers fracture." The articular processes may be fractured with severe injuries to the spine producing dislocation. Stereoscopic antero-posterior, oblique and lateral projections are all necessary for an adequate examination of the posterior arch and its processes. Congenital defects through the interarticular isthmus of the lamina of L 5, are not

infrequent finding and these predispose to an unstable lumbo-sacral junction and may lead to true spondylolisthesis. Separate un-united centers of ossification are common in the transverse process of L-1 and should not be mistaken for fractures. Here one sees a smooth cartilage line instead of the irregular serrated edge of the fracture line.

Although hemangiomas and giant cell tumors may involve the posterior arch of the vertebra, in general tumors and infections of these structures are rare.

### **Common Disorder of the Spine Congenital Anomalies**

The spine, with its many segments and ossification centers, is subject to numerous anomalies and anatomic variations. Most of these are of little or no clinical significance but occasionally the deformity seriously interferes with function and symptoms may be produced. Probably the most common anomaly is failure of fusion of the posterior portion of the neural arch to form the spinus process. This is termed spinabifida and is most commonly seen in the lower lumbar and upper sacral segments. Usually the defect is confined to the bony structure and is termed spina-bifida occulta. This is a frequent finding in otherwise healthy adults. Many anomalies are seen about the lumbo-sacral region where there may appear to be an indecisive delineation between the lumbar type and sacral type of vertebra. Here there may be partial fusion of the first sacral with the second sacral segment. These are termed transitional vertebrae. There may be lumbarization of the first sacral segment or sacralization of the fifth lumbar vertebra. The latter is most common and this type of vertebra may have large transverse processes which show varying degrees of fusion with the sacrum. They are usually thought to be of no clinical significance but at times one does see asymmetrical sacralization of the transverse process with a pseudoarthrosis showing considerable bony reaction. This may be a source of symptoms.

The formation of a supernumerary rib off the transverse process of the first lumbar segment has been previously mentioned and must not be considered a fracture of the transverse process. Occasionally there may be imperfect formation of the body of a vertebra producing a wedge shaped or hemi-vertebrae which may produce a rather severe scoliosis. Fusion of two bodies may be seen occa-

sionally in the upper dorsal or cervical region.

Probably the most common of the significant anomalies is the defect through the inter articular portion of the lamina of the fifth lumbar vertebra which may lead to spondylolisthesis. The congenital defects through the lamina are frequently demonstrated but only rarely does one see complete loss of anchorage with the posterior arch and anterior dislocation of the lumbar spine on the sacrum.

In any examination of the cervical spine for shoulder or arm pain the presence of cervical ribs should be noted. They may be the cause of brachial plexus neuralgia.

### Osteo-Chondritis

Osteo-chondritis is a form of aseptic necrosis, of unknown etiology, which is prone to affect the epiphysis in the weight bearing portion of the body. The secondary centers of the spine are frequently involved, particularly in the dorsal region. Symmetrically wedge shaped deformities of the bodies are likely to result producing a mild to a moderately severe kyphosis. Usually several adjacent vertebra are involved with this symmetrical wedging which should not be confused with a compression fracture. It is likely that Schmorl's nodes, which are produced by herniation of the nucleus pulposus into the epiphyseal plates, may be a complication of osteo-chondritis, although this condition has been regarded by many, as a traumatic lesion. These concave depressions in the superior or inferior portion of the body are frequently seen and are thought to be of no clinical significance.

### Injuries

Compression fracture of the body is probably the most common injury seen in the spine. Significant compression deformity can usually be detected when excellent lateral projections of the involved region are available. They are usually missed because the involved portion of the spine has not been visualized on the film or the technique is so poor that the margins of the bodies are not well visualized. The importance of multiple projections cannot be over emphasized. Where it seems likely that there has been a severe injury to the trunk the entire dorsal and lumbar spine should be well visualized. When a suspicious abnormality of contour is noted, carefully coned down spot films of this region should be made.

Compression injuries may range from almost total destruction of the anterior margin of the body to minimal depression of the anterior and superior margin of the body. Frequently small fragments may be completely displaced from the anterior and superior margin. Lateral studies of the cervical spine are without a doubt the most important projection of this region, when examining for injuries. It is advisable to have more than one study and these films should be made with a six foot tube film distance. The film should not be considered diagnostic unless penetration has been adequate for visualization of all seven cervical vertebra and preferably the body of D 1. This important projection can usually be made without removing the patient from a stretcher or disturbing him in any manner. Antero-posterior projections of the odontoid should be made through the open mouth. If this process has been fractured there will frequently be anterior displacement of the posterior arch of the atlas as seen in the lateral study. The alignment of the bodies and the symmetry of the facets should be carefully observed to detect the possibility of dislocation or subluxation.

Fracture of the upper four dorsal vertebra are fortunately very rare as this area is difficult to visualize in the true lateral plane. Heavily penetrated oblique studies through this region will show the bodies in fairly good profile if an injury is suspected in this region. Fractures of the mid and lower dorsal vertebra are common and should be looked for where there has been crushing injury to the chest with multiple rib fractures. Where there has been gross displacement or dislocation of the vertebra the possibility of fracture of the articular processes and lamina must be considered and stereoscopic antero-posterior and oblique views may be necessary.

Fractures of the transverse processes should be suspected where there is point tenderness in the flank and para spinal region. These fractures are frequently missed because they are not looked for and even when suspected they are difficult to see unless excellent films are available.

### Herniated Discs

Injuries to the intervertebral disc with posterior herniation of the nucleus pulposus are not rare occurrences and the clinical signs and symptoms of this condition



should be known to all who have an interest in the spine. Although the X-ray studies will occasionally show a narrowing of the involved interspace and loss of the normal lumbar lordosis, the presence or absence of these findings neither confirms nor rules out this clinical possibility. If one clinically suspects a ruptured intervertebral disc with posterior herniation this impression should not be altered by lack of positive X-ray signs.

### Arthritis

There are two principal forms of arthritis which may involve the spine; the osteo or degenerative type and the rheumatoid or Marie-Strumpell form. Rheumatoid spondylitis fortunately is rather infrequent. The sacro-iliac joints are usually first involved and the process involves the apophyseal joints in an ascending fashion. Originally there is demineralization of the adjacent subchondral bone about the sacro-iliac region and later there is blurring and irregularity of the joint margins. As the apophyseal joints become involved their outlines are rather blurred and later there is actual destruction of the joint cartilage and eventually ankylosis takes place. A terminal and distinctive feature of the disease is the complete calcification of all the para spinal ligaments producing the so-called "bamboo spine."

The proliferative changes seen about the margins of the bodies so frequently in the older age group producing spurs and lipping about the bodies is often referred to as osteo-arthritis. This is probably not a true arthritis since there is no synovial lining or true articular cartilage involved. These probably represent simple proliferative changes with osteoblastic activity into the attachments of the various ligaments about the region. It seems unlikely that these changes produce pain or other symptoms other than some stiffening of the spine in general. It seems that the term osteo-arthritis of the spine should be reserved for those true forms of degenerative arthritis involving the apophyseal and the only true joints of the spine. This condition is frequently seen in the lower lumbar and lumbo-sacral region where there is narrowing and irregularity of the apophyseal joints with increased bone density of the sub-chondral cortex.

### Infections

Bone destroying infections of the spine, other than Pott's disease, are fortunately

rare. Tuberculous spondylitis is usually easily recognized in its advanced form where there is severe destruction of the bodies and adjacent intervertebral spaces with the sharply localized kyphotic deformity. The condition should be suspected when one sees the paraspinal soft tissue mass on the antero-posterior study. Ordinarily the infection is confined to the bodies and intervertebral spaces but occasionally a rampant process in children will involve the pedicles and posterior arches. Occasionally one or more entire bodies may disappear leaving sharply displaced arches posteriorly. Most all inflammatory lesions of the spine involve, to a certain degree, the cartilage of the intervertebral spaces. This is usually a helpful aid in distinguishing bone destruction secondary to inflammation from that of neoplasms.

Low grade pyogenic organisms occasionally produce infections in the bodies producing a marked increase in bone density and but little bone and cartilage destruction. Typhoid and brucellosis are frequent offenders in the latter group.

### Tumors

Primary tumors of the spine are rather rare; most bone destroying lesions of the spine in adults are metastatic in origin. Neoplasm has great respect for the intervertebral disc and usually the intervertebral spaces are well preserved even where there may be almost total destruction and collapse of the body. Hemangiomas usually arise in the body and may produce collapse due to loss of bone substance. In children one occasionally sees neuroblastomas and metastatic Ewing's tumor destroying the spine in such a rampant fashion as to suggest a tuberculous infection. A paraspinal soft tissue mass is frequently present in the neuroblastoma making the lesion resemble all the more a tuberculous infection.

### Summary and Conclusions

1—Most X-ray examinations of the spine should be tailor-made to fit the clinical possibilities.

2—The importance of multiple projections cannot be over emphasized.

3—The films should be studied in a systematic manner and a definite routine should be established and followed.

4—A knowledge of the common anomalies, injuries and other disorders of the spine and their significance is important.

5—A negative X-ray examination does not necessarily eliminate the possibility of a spine disorder.

### DISCUSSION

**Richard G. Jackson, Danville:** Dr. Miller has ably covered a large subject. There is little to add to his comprehensive presentation and I would like, therefore, only to stress certain features which seem to me to be important to the man who is treating pathologic conditions of the spine. Two facts in regard to fractures, one in regard to arthritis and two in regard to congenital abnormalities seem to me worth emphasizing. First a general statement about fractures: the degree of displacement seen in the X-ray is not necessarily that which existed at the time of injury; inferences must be drawn from the potentialities of the displacement seen in the X-ray rather than from the appearance of the fragments at any one moment. Next I would like to mention a specific fracture. Fractures of the odontoid are among the most dangerous of the fractures of the spine that one is called upon to treat. The open mouth view is very important. The fracture may easily be missed in a regular antero-posterior view of this area. Usually only the open mouth view will show the fracture. There is another lead to this fracture seen in the lateral view: the posterior tubercle of the first cervical never normally projects farther forward than the anterior border of the posterior tubercle of the second cervical vertebra. If it does project farther forward, fracture of the odontoid is usually present. The only other condition which allows this anterior projection is rupture of the transverse ligament behind the odontoid and this is rare.

Symmetrical wedging of a vertebral body is

usually due to juvenile osteochondritis but is sometimes mistaken for fracture. The patient may be subjected to a long course of uncomfortable treatment if this is not kept in mind. One need only remember that juvenile osteochondritis which by the time it is seen in the adult is a stationary condition and needs no treatment, causes the symmetrical wedging to prevent mistaking this for a fracture.

With regard to arthritis, sclerosis about the sacro-iliac joints may be one of the first signs of spondylitis rhizomelique and if this is noticed early the physician may properly advise his patient about the importance of trying to maintain correct posture while the fusion of his spine is occurring, and stress deep breathing exercises to prevent reduction in his vital capacity.

Two facts about congenital abnormality are worth stressing: first, sacralization of the fifth lumbar vertebra may be symptomatic and the thing to look for in the X-ray is sclerosis about the articulation of the transverse process with the sacrum. Secondly, it is important to discover a pars interarticularis defect in patients with low back pain as its discovery before forward slipping of the vertebral body has occurred will enable the physician to correctly advise his patient. If the patient has a sedentary job and subjects his back to strain infrequently, knowledge of the existence of this defect, which creates an unstable back, may be enough to prevent further damage if the patient is advised to avoid heavy lifting, or if lifting is necessary, to lift by bending his knees, keeping his spine straight. If the patient's occupation requires heavy labor it may be necessary for him to wear a brace or have a spine fusion.



# *The* JOURNAL *of the* Kentucky State Medical Association

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## **THE DOCTOR-BLUE-SHIELD RELATIONSHIP**

Blue Shield Plans cannot operate without the cooperation of the medical profession as a whole. Neither can they operate without the cooperation of general practitioners as a component group. Although the ultimate benefits of a successful Blue Shield Plan accrue to the entire profession, it is quite true that the general practitioner does not receive as great a financial return from the plans as do his specialist brethren. Yet, more general practitioners are participating physicians than all of the specialty groups combined.

The fact that Blue Shield Plans enjoy the cooperation of general practitioners is a tribute to the altruism of this group of physicians. It clearly demonstrates their honest interest in the welfare of the people of their communities and their loyalty to the common good of the profession.

As outstanding examples of this spirit of cooperation, we can point to Massachusetts' 6,500 physicians, 98 per cent of whom have signed participating physician agreements with their Blue Shield

Plan, and to Kansas, where there is 99.7 per cent participation. In a number of other states participation exceeds 90% of of the profession.

Kentucky cannot yet be included in this group but ours is a comparatively new plan and participation of Kentucky's doctors is proceeding rapidly and is most encouraging. At the time this is written only 63 additional signatures are needed in 26 counties to permit state-wide sale of Blue Shield contracts. As recently as eight months ago the required 51% of participating physician agreements had been obtained in only 44 counties. This reflects the rapid strides that have been taken by our physicians in rallying to the support of this important function of the profession in our state.

We predict that in a very short time, when our doctors see how successfully the plan is operating, that we too can be included in the list of states in which more than 90% of the profession participates in the Blue Shield Plan.

## PHYSICIANS, HOSPITALS AND THE PEOPLE

The medical profession has enemies. There are not as many of them as there were even a year ago due to actions of the American Medical Association and state and county societies which have resulted in counteracting false impressions made upon the public mind. Even so, it must still be realized that there remain some individuals who look upon the profession as a selfish group interested in feathering its own nest without regard to the effect upon the public. This inimical group, though small, seems remarkably vociferous.

The primary motive of the physician is altruistic. Financial rewards are secondary. "Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption." The obligation to serve suffering humanity is placed upon every physician by the Hippocratic Oath. We realize that there is an occasional physician who is not true to the ethical concepts of the profession. Through the impropriety of the few, the majority of the profession suffers.

Since the profession is under fire from several quarters, it is particularly important that its attitude as a whole and the individual actions of the members be above reproach.

Illustrative of the readiness to overplay weaknesses within the structure of medicine to an unreasonable degree was the article in a recent issue of *Woman's Home Companion* entitled, "Trouble in Our Hospitals," written by Albert Deutsch. Dr. George F. Lull, Secretary and General Manager of A.M.A., and Mr. George Bugbee, Secretary of the American Hospital Association, defended the medical profession and the hospitals in a telegram which was signed jointly and sent to the Chairman of the Board of the Crowell-Collier Publishing Company:

"We wish to protest strongly the tone of 'Trouble in Our Hospitals' by Albert Deutsch in the current issue of *Woman's Home Companion*.

"While it is true there are some areas of disagreement between physicians and hospitals—just as there are in all human relationships—the author of this article has magnified these differences of opinion out of all proportion to the truth. His statement that 'The A.M.A. and the hospitals, which should be

marching hand in hand toward better services for the sick, are locked in combat,' is nothing short of sensationalism.

"The doctors and hospitals have always cooperated in efforts to deliver the best possible medical care and will continue to do so. Any differences are being ironed out peaceably around the conference table."

Hospitals are institutions in which medical care is extended to the sick. Physicians should supply the medical care and the hospital should provide the facilities for such care as well as certain supportive services. Since medical care can be given only by physicians, it is impossible for a hospital to practice medicine without the cooperation of the medical profession or at least some of the members of the profession. Provision of medical care by hospitals through employment of physicians constitutes the practice of medicine by a corporation which is illegal in most states. Relaxation of the profession's position upon this phase of the problem would have the effect of reducing the physician to the status of a mechanic who is paid at a certain hourly rate while the person receiving his services is charged at a higher rate, permitting a profit to accrue to the employer. The physician would lose professional status and the quality of medical care would inevitably deteriorate. No thinking person sincerely interested in medical care could expect the profession to assume any other position than that which it presently occupies.

Although this is a serious question and one upon which the profession cannot yield, it must not be permitted to influence the availability of medical care to the people or to cause the people to think of themselves as victims of this difference of opinion.

Hospitals and doctors will, as stated by Dr. Lull and Mr. Bugbee, continue to cooperate as they always have in the past in caring for the sick and in ironing out those differences which exist. We cannot conceive of a situation developing which would affect the care of the people but it is highly possible, especially if encouraged by the appearance of misleading articles in publications with national distribution, for the people to be led to believe that they are caught in the middle. This must not be permitted to occur.



## THE NATIONAL FUND FOR MEDICAL EDUCATION

The formation of the National Fund for Medical Education was recently announced in New York City. Its purpose is to provide financial assistance to the Nation's hard-pressed medical schools. The organization has the support and sponsorship of industry, organized labor, agriculture, the medical profession, a group of university presidents and twelve scientific and educational foundations.

The American Medical Education Foundation which was organized by A.M.A. last December will turn over all funds which it receives to the new group to be funneled to medical schools.

Mr. S. Sloan Colt, Fund President and President of Bankers Trust Company of New York, announced that initial contributions, which have come from a wide spectrum of the American community, total \$1,000,000. These funds are to be distributed immediately.

The American Medical Association was criticised roundly for opposing Federal aid to medical education. Some said that doctors were attempting to prevent competition by limiting the number of physicians that are being educated. Such criticism is to be expected when a stand is taken upon a matter of principle.

Most American citizens disapprove paying a lion's share of the tax dollar to the Federal government and then lining up at the Federal feed trough in an attempt to get some of it back to spend at the local level. A dollar cannot make a more expensive trip than to Washington and return. Yet, like the weather, few people do anything about it. The practice con-

tinues and a vicious cycle is created. Since the cream of available tax resources goes to the Federal government, only skimmed milk is left to support local government—the quality and quantity of whose services often reflect the state of their nutrition.

Through this process a great deal of American resourcefulness has been lost in our communities. It is easier to pass the responsibility for functions that properly belong to local government along to the Federal government than it is to assume the responsibility of financing them from community resources.

How can the cycle be broken? Only through the courageousness of individuals and groups who are willing to stick out their chins by assuming local financial responsibility for local problems.

The A.M.A. took such a stand when they refused to approve Federal aid for medical education. It was felt that a principle was involved which is essentially wrong. It was also believed that such action was unnecessary and that private funds would be forthcoming to support medical schools in addition to state and local tax dollars in some instances. Whether or not sufficient funds will be collected to meet the needs of the schools remains to be seen. With such powerful support as The National Fund for Medical Education has behind it, we believe it will be successful. All Americans should be proud of the effort and be ready to support leaders with sufficient courage to make the attempt.

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### EDITORIAL COMMENTS

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**Gains are reported by Surgeon General Leonard A. Scheele** in the 1950 annual report of the Public Health Service in the medical and related sciences, in the Nation's health resources, and in State and local health agencies.

Vital statistics contained in the report show that the 1949 death rate followed the same declining trend which has been shown for the past 10 to 20 years. In 1949, the death rate declined from 9.9 per 1,000 population in 1948, to 9.7 per 1,000. Although 3.7 million babies were born in the United States in 1949—fewer infants

died in the first year of life. Maternal deaths also declined. In 1949, the infant mortality rate was 31 for every 1,000 live births, and the maternal mortality rate was 9 per 10,000 live births. The birth rate was 24.1 per 1,000 population as compared with 24.2 in 1948.

Deaths from chronic diseases showed little change from the 1948 figure, although mortality from these diseases has been mounting with the growing and aging population. Heart disease and cancer continued to hold the first and second places in the list of the more frequent killers.

These two causes together accounted for half of the 1,446,000 deaths from all causes in 1949. The death rate from heart diseases was 20 per cent higher than in 1940; the cancer death rate was 15 per cent higher. Fewer cases of diphtheria, influenza, malaria, scarlet fever, whooping cough and smallpox were reported in 1949 than in any other year. In contrast, new highs were reported for chickenpox, amebic dysentery and poliomyelitis.

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**Due to a shortage in chemicals used for chlorination,** the entire available supply will be required this summer to protect water supplies. None will be permitted to be used in swimming pools.

Since this situation could result in an increase in the incidence of typhoid, Dr. C. E. Reddick, Director of the Division of Local Health Services of the State Health Department, has advised that all persons swimming in the unprotected pools be immunized.

Cooperation of the profession is urged.

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**Using a synthetic antigen to replace an extract of human cancerous liver tissue,** a sero-flocculation test is reported to be more than 98% per cent accurate in confirming positive diagnoses of malignancy.

The work was reported recently before the annual meeting of the American Association for Cancer Research, by Drs. Claude S. Mumnia and F. X. Byron, of the Los Angeles VA Hospital.

The chief value of the test is said to be in permitting earlier diagnosis. Although the test yielded 28 per cent false positives in 315 non-malignant lesions, biopsies and other examinations clarified the diagnosis. The test shows promise of becoming a valuable screening procedure.

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**Dr. Jack C. Haldeman,** former Health Officer of the Christian County Health Department, has been appointed as Chief of the Division of State Grants of the U. S. Public Health Service.

In his new position he replaces Dr. Estella Ford Warner in administering the multi-million dollar program of grants-in-aid to the states for development of public health. Dr. Warner has been assigned to a mission in Bierut, Lebanon.

Since 1948 Dr. Haldeman has been Medical Director of the Arctic Health Research Center in Anchorage, Alaska, where he

has been responsible for extensive studies of communicable and nutritional diseases and sanitation problems peculiar to low temperature areas.

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**The "Hypospray" Jet-Injector,** an instrument for giving an injection without a needle, is being introduced in Akron and Canton, Ohio by E. R. Squibb & Sons acting for the R. P. Scherer Corporation of Detroit, producer of the instrument.

The Jet-Injector sends a tiny jet at high velocity through the skin to the desired depth for intramuscular or subcutaneous injection.

The instrument is a little smaller than an ordinary two-cell flashlight and weighs about the same.

Into the nosepiece is inserted a sterile cartridge holding the medication to be injected. It is made of a special steel alloy. A spring-activated plunger is released forcing a high velocity jet of medication through a minute opening at the tip of the cartridge. The cross section area of this jet is approximately twenty-two times smaller than the smallest hypodermic needle commonly in use and it is said that comparatively few pain fibres are affected and the tissue is subject to much less damage. After penetration, the jet diffuses more widely than a needle injection, thus bringing about better absorption of the medication. The jet penetrates the tissues to a desired depth through adjustments of the "Hypospray" which makes it possible to allow for differences in age and skin thickness of patients at the site of injection. One of the obvious advantages, especially for children, is the relative freedom from fear of the needle.

Since no part of the instrument comes in contact with the medication to be injected, it does not require sterilization.

A wide variety of medications including such antibiotics as penicillin and streptomycin, narcotics such as methadone and morphine, anti-anemia and nutritional products, endocrines and certain biologicals are now available.

Articles pertaining to the development and use of the "Hypospray" have been occurring in various journals and other medical publications for about two years.

The manufacturers state that the instrument will be made available to physicians in other parts of the country as rapidly as production will permit.



# ORGANIZATION SECTION

## Luncheon Honoring Guests to Be Feature of Centennial

A luncheon honoring the Kentucky-born or -educated physicians who have distinguished themselves outside of the state and who will present the Scientific Program at our Centennial meeting will be held Wednesday, October 3, on the Roof Garden of the Brown Hotel.

This information, plus a complete report of the plans and recommendations of the Centennial Committee for the annual meeting, October 2, 3 and 4, celebrating the 100th birthday of this Association was given the Council by Sam A. Overstreet, M. D., Chairman of the Committee, at its May 10 meeting.

The Centennial Committee, Dr. Overstreet told the Council, had undertaken to make the Scientific Program outstanding. It was felt by the Committee that this program would compare most favorably in quality with most national meetings.

Other features include over 500 feet of high-calibre scientific exhibits, with both state and nationally known men participating, 64 technical exhibits, scientific movies and special historical exhibits. These features, the annual public meeting and Centennial Banquet will be fully covered in subsequent issues of the Journal.

## Class Reunion Chairmen Announced For Centennial Meeting

Plans for Class Reunions of 1901, '11, '21, '31 and '41 of the U. of L. Medical School to hold meetings during the Centennial Celebration are being completed, Leslie Shively, secretary of the Alumni Relations at the University has announced.

Special tables will be reserved at the Centennial Banquet for each class and the groups will be properly recognized. The Headquarters Office is cooperating in the promoting of these reunions.

The following men are the Chairmen of the five classes to be represented:

Class of 1901—E. S. Allen, M. D., Francis Bldg., Louisville

Class of 1911—Cecil G. Harrod, M. D., Columbus, Indiana

Class of 1921—D. P. Hall, M. D., Heyburn Bldg., Louisville

Class of 1931—William Ray Moore, M. D., 2039 Frankfort, Louisville

Class of 1941—Sam Clark, M. D., Heyburn Bldg., Louisville

## U. of L.-K.S.M.A. Refresher Course For Summer Announced

The following announcement covering Postgraduate Refresher Courses sponsored by the U. of L. School of Medicine and the Kentucky State Medical Association has been issued by Herbert L. Clay, M. D., Director of Postgraduate Refresher Training of the University.

In addition to the Medical Seminar in June a number of courses are planned for the next year. These are to be conducted throughout this state so that all courses may be made available to all areas of the state during the next three years. Some courses are to be held two hours, one night a week for several weeks; some are to be conducted on Sunday from 10:00-12:00 and 1:00-4:00 for one or two periods; and others are to be for one or two days. Tuition for these courses will be 20 hours—\$25.00; 15 hours—\$15.00; 8 to 10 hours—\$10.00; 2 days—\$10.00; and 1 day—\$5.00.

1. Chest Surgery—8 hours: (1) Mammoth Cave, August 5, September 9, (2) Hopkinsville, July 6, 13, 20
2. Dermatology—10 hours: (1) Louisville, July 6, 13, 20, 27, Medical Department Conference Room, Louisville General Hospital, (2) Hopkinsville, August 19, September 16
3. Electrocardiography—20 hours: (1) Somerset, July 6, 13, 20, 27, August 3, 10, 17, 24, 31, September 7, (2) Louisville, September 12, 19, 26, October 10, 17, 24, 31, November 7, 14, 21, Louisville General Hospital
4. Hematology—20 hours: Lexington—date announced later
5. Medicine Course—10-12 hours: Louisville, 2 days in January or February 1952. Conducted by Jewish Hospital Division of the University of Louisville Medical Center
6. Medical Seminar: Louisville, October 5, Louisville General Hospital, in conjunction with K.S.M.A. meeting
7. Neurosurgery—10 hours: (1) Mammoth Cave, June 10, July 8, (2) Middlesboro, August 26, September 16
8. Urology—10 hours: (1) Paducah, August 10, 17, 24, 31, September 7, (2) Ashland, August 24, 31, September 7, 14, 21

### **Georgetown, U. of K. Win Auxiliary College Editors' Contest**

Georgetown College won the first prize of fifty dollars, and the University of Kentucky was awarded second prize of twenty-five dollars, in the college editors' contest sponsored by the Woman's Auxiliary to the Kentucky State Medical Association. Mrs. Clark Bailey, Harlan, President of the Auxiliary, has announced.

The purpose of the contest, which ran from November 11, 1950, to February 22, 1951, was to stimulate interest and thought in the minds of students on the subjects of Americanism and freedom. It is understood that the money will be used to purchase history books for the libraries of the winning colleges.

The judges were Mrs. William Noel, Harlan, State Americanism Chairman of the D. A. R.; Mrs. Sam Flowers, Middlesboro, Editor of the Blue Grass News; and Mr. Robert Poisall, former Field Secretary of the Kentucky State Medical Association.

### **Kentuckians to Exhibit at A.M.A. Atlantic City Meeting**

Of the 287 exhibits in the Scientific Hall, scheduled for the annual A.M.A. Meeting in Atlantic City June 11, three are being sponsored by Kentucky, it is reported in the April 14 issue of the Journal of the A.M.A. They are:

Section on Radiology—"A New Teaching Aid for Use in Diagnostic Roentgenology"—Everett L. Pirkey, I. R. Berger, James E. Parker, and Frank W. Shook; University of Louisville School of Medicine, Louisville.

Section on Surgery, General and Abdominal—"Abdominal Aortography"—Alvin B. Ortner, Robert Lich, and David Shapiro; University of Louisville Hospitals, Louisville.

Section on Miscellaneous Exhibits—"McDowell Memorial"—Charles A. Vance, Mrs. Walker Owens, and Mrs. E. L. Henderson; McDowell Memorial Foundation, Danville, Kentucky.

### **Student A.M.A. Told Service Is Most Important Ideal**

"Men who have amounted to the most in medicine are the men who have kept foremost in their minds the ideal that the medical profession is devoted to service," Sam A. Overstreet, M. D., Louisville, President of the State Association, told a meeting of the University of Louisville Society of the Student A.M.A.

Speaking on the subject "The Pattern of Medicine Today and Tomorrow," Dr. Overstreet appealed to the students to make the most of the wide opportunities provided in medicine. "No profession offers such a wide and fruitful field as does ours."

Dr. Overstreet urged the students to keep in proper perspective the various branches of the profession. He pointed out that each field in medicine, whether it be research, teaching, Public Health, or private practice, was dependent on the others for success. The need of co-operation within the profession was stressed.

### **Dr. Kline to Succeed Dr. Henderson at Atlantic City Session**

Elmer L. Henderson, M. D., Louisville, following an active and colorful administration, will retire as the seventh Kentucky physician to be President of the A.M.A., at the Atlantic City Meeting, starting June 11.

Dr. Henderson will surrender the gavel to John W. Kline, M. D., San Francisco, the President-Elect. Dr. Henderson was inaugurated in a dramatic ceremony at the San Francisco Meeting which provided the setting for the first nation-wide radio broadcast, sponsored by A.M.A.

When the retiring President was installed, Kentucky became the first state to produce seven A.M.A. Presidents. Dr. Henderson is also President of the World Medical Association and the A.M.A. National Education Foundation—which was established during his tenure of office.

In addition to being a Past President of the K.S.M.A., Dr. Henderson is a Past President of the Southern Medical Association and is former Chairman of the A.M.A. Board of Trustees.

### **Louisville Psychiatrist Appointed Head of Mental Hospitals**

Frank M. Gaines, Jr., M. D., Louisville, has been appointed by Governor Wetherby as State Director of Hospitals and Mental Hygiene, to succeed A. M. Lyon, M. D., who resigned the post last February.

Dr. Gaines was clinical director of the Norton Memorial Infirmary Psychiatric Clinic, Louisville, and will, in his new position, have charge of the four mental hospitals in the State and the Kentucky Training Home for the Feeble-minded at Frankfort.

A graduate of the University of Louisville Medical School in 1941, Dr. Gaines served as captain in the Army Medical Corps for three



years during World War II. His residency work was done at Louisville General Hospital, with postgraduate work at New York Hospital. He became clinical director of Norton's Infirmary in 1949.

### **Fayette Annual Session Attracts 200 to Lexington May 8**

More than 200 physicians from Lexington and the surrounding territory attended the annual dinner meeting of the Fayette County Medical Society at the Lexington Country Club, Tuesday evening, May 8.

Murray M. Copeland, M. D., Professor of Oncology, Georgetown University Medical School, Washington, D. C., gave a well illustrated lecture on "Premalignant Lesions of the Breast—Their Diagnosis and Treatment."

William H. Pennington, M. D., Lexington, President of the Society, presided. Arrangements for the meeting were made by John S. Sprague, M. D., Lexington, Secretary.

Sam A. Overstreet, M. D., Louisville, President, and Clark Bailey, M. D., Harlan, President-elect of the Kentucky State Medical Association, were among the guests.

### **Seventh District Plans June 28 Meeting at Frankfort**

The Seventh Councilor District will hold its first meeting since redistricted in 1950, at the Frankfort Country Club, Thursday, June 28, at 6:00 p.m., Central Daylight Time, B. B. Baughman, M. D., the Seventh District Councilor, has announced.

As the May 10 deadline is met for the June Journal, Dr. Baughman said he had not completed his program but he did indicate the papers would be read by men from within the District.

Those who wish to play golf are invited to play at the Country Club course that afternoon. Wives of the doctors will be urged to attend. Following the dinner, the women who do not wish to hear the scientific session will find card tables in another room to which they may withdraw.

### **Fourth District to Meet June 27**

J. I. Greenwell, M. D., New Haven, Councilor for the newly-formed 4th District, is planning a dinner meeting for the physicians and their wives of his district at the Bardstown Country Club, at 6:30 P. M., Wednesday, June 27.

As the deadline for this issue was met, Dr.

Greenwell had not completed his program for this meeting, but stated that ample information would be sent his members well in advance of the meeting. He expects to have an unusually good scientific program.

### **New Third District's First Meeting Scheduled June 12**

The Christian County Medical Society will entertain the physicians of the newly-formed Third Councilor District with a dinner and program on the treatment of atomic illness at the Western State Hospital in Hopkinsville, at 6 P. M., Tuesday, June 12, 1951.

"Clinical Problems and Radiation Sickness" will be the title of a paper given by Robert M. Coleman, M. D., Hopkinsville. Roy H. Moore, Jr., M. D., Louisville, will discuss "Mass Treatment of Traumatic Injuries." The program will be concluded with a film called "Medical Aspects of Atomic Bomb."

The program is being sponsored by the Association's Committee on Emergency Medical Service, of which Pat R. Imes, M. D., Louisville, is Chairman, in co-operation with the State Civilian Defense Organization. Dentists in the Third District will be invited.

Delmas M. Clardy, M. D., Hopkinsville, President of the Christian County Society and Councilor for the new Third District, and J. E. Baker, M. D., Secretary of the Christian County group, are making the local arrangements.

### **Insurance Committee Tells Council Results of Investigation**

The new insurance code that became effective in Kentucky, September 1, 1950, will automatically eliminate companies writing inferior individual coverage in the hospital payments and medical care field, in a matter of months, Clyde C. Sparks, M. D., Ashland, Chairman of the Advisory Committee on Health Insurance, told the Council at its May 10 meeting.

Dr. Sparks' committee was activated in the fall of 1950 to explore the field of commercial companies underwriting individual hospital payments and medical care insurance. It was instructed to recommend to the Council, if it were deemed necessary, a list of reputable companies which members of the Association might give to interested patients seeking adequate coverage.

The Council was told the committee met with the Department of Insurance officials at Frankfort and that the Department was most helpful and cooperative in giving the committee basic information. The Chairman said the committee was very favorably impressed by

the Insurance officials' attitude.

The Council accepted the committee's recommendations which included: (1) that each doctor study the financial status of the companies operating in his area; (2) that each doctor make a study of the service offered by the local adjusting agency; and (3) that each doctor endeavor to educate the people in his community to read and study policy clauses before purchasing.

### Atomic Illness Programs Presented

Two programs, sponsored by the Committee on Emergency Medical Service of the Association, in cooperation with the State Civilian Defense Organization, on the treatment of atomic illness, were held in May.

Gerald M. Peterson, M. D. and George B. Sanders, M. D., both of Louisville, gave the program in Lexington, May 29. Alfred O. Miller, M. D. and William H. Bizot, M. D., both of Louisville, participated in a program at Paducah May 8.

A film was shown in conjunction with each program and dentists were invited.

### Article to Discuss Doctor Shortage

"What About the Doctor Shortage" is the title of a medically significant article to appear in the June **Readers Digest**, advance information reaching this department just prior to our May 10 deadline for this issue states.

Paul de Kruif is the author of the article which will be of great interest to both lay and professional readers. Mr. de Kruif wrote "Your Doctor for a Friend," which appeared in the May issue of the **Readers Digest** and which pinpointed the importance of physicians organizing emergency call services in every community.

### Pediatricians Elect New Officers

Leonard T. Davidson, M. D., Louisville, Professor of Pediatrics at the University of Louisville School of Medicine, was elected President of the Kentucky Society for the Advancement of Pediatrics at its second annual meeting which was held in Louisville, April 26, 1951, succeeding Harry S. Andrews, M. D., Louisville.

William T. Maxson, M. D., Lexington, was made Vice-President to take the place of Thomas J. Marshall, M. D., Paducah. Cathryn C. Handelman, M. D., Louisville, Director of Maternal and Child Health at the State Department of Health, was re-elected Treasurer. All physicians interested in treating babies and children are invited to join the organization.

### Dr. Yates to Head E.E.N.T. Section

E. Carroll Yates, M. D., Lexington, was elected President of the Eye, Ear, Nose and Throat Section of the Kentucky State Medical Association at the annual meeting in Louisville April 18 and 19.

Dr. Yates succeeds W. C. Wells, M. D., Glasgow. Other officers elected were: Charles T. Moran, M. D., Louisville, Vice-President; Wynant Dean, M. D., Louisville, Secretary; and R. A. Gettlefinger, M. D., Louisville, Treasurer.

The guest speaker, Ramon Castroviejo, M. D., of New York City, presented his original work on the treatment of glaucoma.

### Education Committee Appointees Announced By President

R. Haynes Barr, M. D., Owensboro, was again named Chairman of the Education Campaign Subcommittee by Sam A. Overstreet, M. D., Louisville, President of the Association. Other members of the committee are listed by Council Districts and counties. They are:

**FIRST COUNCILOR DISTRICT:** Carlisle—J. F. Harrell, Bardwell; Fulton—R. Ward Bushart, Fulton; Graves—James W. Fuller, Mayfield; Marshall—George C. McClain, Benton; McCracken—R. W. Robertson, Paducah.

**SECOND COUNCILOR DISTRICT:** Daviess—Charles B. Wathen, Owensboro; Hancock—F. M. Griffin, Hawesville; Henderson—Walter L. O'Nan, Henderson; McLean—A. B. Colley, Calhoun; Ohio—Fred C. Reynolds, Jr., Hartford; Union—Dudley B. Smith, Morganfield; Webster—William W. Wainer, Providence.

**THIRD COUNCILOR DISTRICT:** Caldwell—B. K. Amos, Princeton; Christian—J. G. Gaither, Hopkinsville; Hopkins—John E. Haynes, Dawson Springs; Lyon—M. H. Mosley, Eddyville; Muhlenberg—John P. Walton, Central City; Todd—Ralph D. Lynn, Elkton; Trigg—John Futrell, Cadiz.

**FOURTH COUNCILOR DISTRICT:** Grayson—Charles L. Sherman, Millwood; Green—James W. Miller, Greensburg; Hardin—William H. Barnard, Elizabethtown; Hart—James W. York, Canmer; Larue—John D. Handley, Hodgenville; Marion—W. Burr Atkinson, Lebanon; Meade—Alfred Glattauer, Brandenburg; Nelson—W. Keith Crume, Bardstown; Spencer—Martin H. Skaggs, Taylorsville; Washington—D. E. Snider, Springfield.

**FIFTH COUNCILOR DISTRICT:** Jefferson—J. Andrew Bowen, Louisville.

**SIXTH COUNCILOR DISTRICT:** Adair—Nathaniel A. Mercer, Columbia; Allen—Earl P. Oliver, Scottsville; Barren—William H. Bryant, Glasgow; Butler—D. G. Miller, Jr., Morgantown; Edmonson—Marcus B. Wilkes, Jr., Brownsville; Logan—C. A. Wood, Auburn; Metcalfe—Elgin S. Dunham, Edmonson; Monroe—Tim Lee Carter, Tompkinsville; Simpson—Lillard F. Beasley, Franklin; Warren—William R. McCormack, Bowling Green.

**SEVENTH COUNCILOR DISTRICT:** Anderson—R. N. Lawson, Lawrenceburg; Carroll—Edgar S. Weaver, Carrollton; Franklin—Clarence T. Coleman, Frankfort; Gallatin—Harry K. Dillard, Warsaw; Henry—C. Wyatt Norvell, New Castle; Oldham—John T. Walsh, LaGrange; Owen—John F. Berry, Jr., Owenton; Shelby—Benjamin F. Shields, Shelbyville; Trimble—O. James Hurt, Bedford.

**EIGHTH COUNCILOR DISTRICT:** Campbell—Arthur E. Schultz, Newport; Kenton—Norman Adair, Covington.

**NINTH COUNCILOR DISTRICT:** Bath—B. Ralph Wilson, Sharpburg; Bourbon—William W. Dye, Paris; Bracken—James M. Stevenson, Brooksville; Fleming—Ben F. Allen, Flemingsburg; Harrison—H. Todd Sniser, Cynthia; Mason—Harold N. Parker, Maysville; Nicholas—B. F. Reynolds, Carlisle; Pendleton—William M. Townsend, Falmouth; Robertson—Perry Overby, Mt. Olivet; Scott—Frederick W. Wilt, Georgetown.

**TENTH COUNCILOR DISTRICT:** Fayette—John S. Sprague, Lexington; Woodford—Benjamin F. Roach, Midway.



**ELEVENTH COUNCILOR DISTRICT:** Clark—Vernon O. Kash, Winchester; Estill—Samuel G. Marcum, Irvine; Jackson—Arch B. Clark, McKee; Lee—Albert B. Hoskins, Beattyville; Madison—J. Bates Henderson, Berea; Montgomery—Joe M. Bush, Mt. Sterling; Owsley—Don E. Wilder, Booneville; Powell—I. W. Johnson, Stanton; Wolfe—John L. Cox, Campton.

**TWELFTH COUNCILOR DISTRICT:** Boyle—Charles W. Caldwell, Jr., Danville; Casey—Garnett J. Sweeney, Liberty; Clinton—Ernest A. Barnes, Albany; Garrard—Paul M. Sides, Lancaster; Lincoln—Thomas J. Wright, Stanford; McCreary—Grover C. Meece, Whitley City; Mercer—C. B. Van Arsdall, Harrodsburg; Pulaski—Richard H. Weddle, Somerset; Rockcastle—George H. Griffith, Mt. Vernon; Russell—M. M. Lawrence, Jamestown; Wayne—Frank L. Duncan, Monticello.

**THIRTEENTH COUNCILOR DISTRICT:** Boyd—Mathew D. Garred, Ashland; Carter—Grady C. Stewart, Olive Hill; Elliott—John F. Greene, Sandy Hook; Greenup—Charles B. Johnson, Russell; Lewis—Herbert M. Bertram, Jr., Vanceburg; Lawrence—G. Philip Carter, Louisa; Morgan—Alec Spencer, West Liberty; Rowan—I. M. Garred, Morehead.

**FOURTEENTH COUNCILOR DISTRICT:** Breathitt—Myrvyn E. Hoge, Jackson; Floyd—George Archer, Prestonsburg; Johnson—D. H. Dorton, Jr., Paintsville; Knott—M. F. Kelly, Hindman; Letcher—Ernest G. Skaggs, Fleming; Magoffin—Lloyd M. Hall, Salyersville; Martin—William N. Keith, Inez; Perry—Lawrence H. Wagers, Blue Diamond; Pike—Francis H. Hodges, Pikeville.

**FIFTEENTH COUNCILOR DISTRICT:** Bell—Charles B. Stacy, Pineville; Clay—William E. Becknell, Manchester; Harlan—Philip J. Begley, Harlan; Knox—Theodore R. Davies, Barbourville; Laurel—Boyce E. Jones, London; Whitley—Keith P. Smith, Corbin.

### Dr. Barr's P. R. Speech Complimented

R. Haynes Barr, M. D., Owensboro, Chairman of the Education Committee, received special recognition by the Public Relations Department of the A.M.A. for his speech at our County Society Officers Conference.

The A. M. A. "P-R Doctor" carried a complimentary statement on the talk. In addition, a copy of Dr. Barr's talk in its entirety was enclosed in the A.M.A.'s kit that is issued by the Public Relations Department every three months. This kit is sent to all State Medical Associations and to County Medical Societies who are on its mailing list.

### Kentuckians Participate in Surgical Congress Meeting

C. C. Howard, M. D., Glasgow, retired as president of the Southeastern Surgical Congress at its 19th annual meeting at the Hollywood Beach Hotel at Hollywood, Florida, April 11-14.

Joseph S. Stewart, M. D., Miami, Florida, succeeded Dr. Howard as president. Dr. Howard, who is the Chairman of the Council of the Kentucky State Medical Association and a recent past-president, gave a paper at the meeting entitled, "Accidents and a Proposed Program of Prevention."

Other Kentuckians on the program were Elmer L. Henderson, M. D., Louisville; Herman Mahaffey, M. D., Louisville; and Clyde C. Sparks, M. D., Ashland.

### Eastern Group Meets at Ashland

More than 60 physicians attended the annual meeting of the Eastern Kentucky Medical Association in Ashland May 3.

At the afternoon session, Walter S. Coe, M. D. and J. Ray Bryant, M. D., both of Louisville, and Leonard B. Greentree, M. D., of the Ohio State Medical School, gave papers.

Following refreshments and dinner, papers were presented by Clyde C. Sparks, M. D., and B. B. Holt, M. D., both of Ashland. Wendell Lyon, M. D., Ashland, is President of the Association.

### Sixth District Hears Pediatricians

The Sixth Councilor District, of which C. C. Howard, M. D., Glasgow, is Councilor, held its first meeting of the year at the Helm Hotel in Bowling Green, Tuesday, May 8.

At both the afternoon and the evening sessions, the program was presented by the Pediatrics Department of the U. of L. Medical School. The afternoon talks were given by Robert E. O'Connor, M. D., Joseph A. Little, M. D. and William A. Brodsky, M. D. The speakers at the after dinner session were Leonard T. Davidson, M. D. and J. Ray Bryant, M. D.

### General Practice Award

The Academy of General Practice of Kentucky is offering an award for the best paper submitted on any subject pertaining to general practice. Dr. D. G. Miller, Jr., Morgantown, Kentucky, Secretary-Treasurer of the Kentucky Academy of General Practice, has supplied the rules governing the award as follows:

1. Any general practitioner in Kentucky may submit a paper based on original work he has done as a general practitioner.
2. Paper to be typewritten, double spaced, on one side of plain white paper, bearing no name, sealed envelope to be clipped to paper containing name and address of physician submitting the paper.
3. Paper must be submitted before July. Send to Academy office in Morgantown, Kentucky.
4. May be on any subject the writer wishes.
5. Will be judged by three University of Cincinnati physicians.
6. Award will be based on originality and practicability of research.

## *Pertinent Paragraphs*

**George Lull, M. D., Secretary and General Manager** of the American Medical Association, was a visitor to the Headquarters Office on Derby Eve. We appreciated Dr. Lull's visit, and much helpful information was derived from our discussion with him. Following the Derby, he was to fly to Pinehurst, North Carolina, for the annual meeting of the North Carolina Medical Association.

**Maysville was the first city in Kentucky** to adopt flouridation of its water system. Greensburg and Louisville were expected to follow within a short time. The process was suggested by the Kentucky Dental Association as a means of reducing tooth decay.

**Several thousand persons were attracted by** the dedication ceremony of the new Covington-Kenton County Tuberculosis Sanatorium at Covington on April 15. Major credit for the new hospital is given James A. Ryan, M. D., a Past-President of the Southern Medical Association, and now President of the Sanatorium. George N. Burger, M. D., Covington, is Vice-President and Charles J. Farrell, M. D., Covington, is Medical Superintendent.

**The Servicemen's Indemnity and Insurance Act** of 1951, designated as Public Law 23, 82nd Congress, became effective April 25 with the signature of the President. The Veterans Administration has sent us information on this new law, sometimes referred to as "free GI insurance bill." If any of our veteran members would like information on this matter, please contact the Headquarters Office.

**Visitors to the new Ohio State University Medical Center** will be able to tour the four new buildings, one of which is occupied by the new dental school. One of the buildings will be the new 600-bed University Hospital; another, a 300-bed Tuberculosis Hospital; and the fourth, the Columbus Receiving Hospital with 140 beds.

**A new service is being made available** to physicians and hospitals by the A.M.A. Council on Medical Education and Hospitals to provide information regarding the openings for appointments to approved residencies. Physicians may obtain on request lists of residencies

available, together with details as to the number of positions open, the name of the chief of service, the salary, etc.

**The Veterans Administration has announced** that the first checks for the second special dividend of \$685,000,000 to be paid GI insurance policyholders have been mailed. The checks cover dividends due on some of the policies with anniversary dates falling during the month of January. One year, approximately, will be needed for completion of payment of the dividend.

**At the fourth annual meeting of the Kentucky Obstetrical and Gynecological Society**, held at Ashland, Friday, April 6, Howard Maloney, M. D., was elected president, succeeding Clyde C. Sparks, M. D., of Ashland. C. J. McDevitt, M. D., Murray, was made Vice-President, J. B. Marshall, M. D., Louisville, was re-elected as Secretary-Treasurer, and Robert Eatemen, M. D., Somerset, was made a member of the executive committee.

**A total of 44 clinics and 118 companies** cooperated in a survey in the attempt to establish regular periodic health examinations for the executive management group in industry. The Metropolitan Life Insurance Company, who sponsored the survey, has reported that approximately 400 companies in the United States and Canada have already developed programs for safeguarding the health of the executive group during periods of emergency.

**The Arthritis and Rheumatism Foundation** is offering research fellowships in the basic sciences related to arthritis, at predoctoral and postdoctoral levels. The predoctoral fellowship range is from \$1,500 to \$3,000 per annum, and the postdoctoral from \$3,000 to \$6,000. Applications should be mailed before November 15, 1951, to Arthritis and Rheumatism Foundation, 535 Fifth Avenue, New York 17, New York.

**An all-time high of 209,040 physicians** are now licensed to practice in continental United States, the annual medical licensure report of the A.M.A. shows, Donald G. Anderson, M. D., of the A.M.A. Council on Medical Education and Hospitals, has announced. There were 6,002 additions to the medical profession in the U. S. and possessions last year. Of this number 3,794 died, making a net gain of 2,208. Of the 4,955 graduates of medical schools in this country who took state boards last year, 97.1% passed.



## KENTUCKY PROCUREMENT COMMITTEE NEWS

by

A. Clayton McCarty, M. D., Chairman

### County Societies Are Asked to Name Procurement Committees

While the final decision on what is to be recommended to Selective Service on any given special registrant is with the Kentucky Procurement Committee, our group does expect to lean almost entirely upon the recommendations of the local committees and Councilors in these cases.

Your State Committee feels that each County Society should have a County Procurement Committee to advise on the availability of men in that county. This Committee should be composed of the President and Secretary of the County Society plus a third member chosen by the Society, or a Committee of three may be elected by the Society.

Each Society is urged, however, to notify the State Committee as early as possible of those composing the County Procurement Committee.

### Need of Advising the Procurement Committee Is Stressed

Physicians who have sought and obtained the advice of the Kentucky Procurement Committee for Military Service should keep the Committee informed of all developments on the matter in their situations on all occasions.

The Procurement Committee reached this conclusion at its meeting May 13. It strongly urges each special registrant or inactive reserve officer, in whose case the Committee has reached a decision, not to act independently of the Committee until after consultation with it.

The Committee feels much time and effort will be conserved if such a practice is followed. In addition, this cooperation will enable the Committee to render a more efficient service to the medical profession, the public and the Armed Forces.

### Defense Department to Call 717 Physicians in July

The Defense Department has asked Selective Service to provide it with 717 physicians for July, 333 for August and 152 for September, to be taken from men classified in Priority I, according to information received by the Kentucky Procurement Committee.

The call was made necessary, the Department said, because physicians in Priority I

were not volunteering in sufficient numbers to meet the requirements of the Armed Forces.

Under Public Law 779, all available physicians in Priority I will be called before Priority II is approached. The youngest physicians in Priority I will be taken first.

Applying for a commission before being drafted will enable the physician to get a commission but will not delay induction. If the number of volunteers increase, the number of physicians to be drafted will decrease in a corresponding manner.

### Army to Call 105 Reservists in June Will Give 30-Day Notice

The Department of the Army will call 105 Army Medical Service Reserve Officers into active service in June, the Defense Department has announced.

These officers will be given at least 30 days to terminate their business and personal affairs. The entire group is in the Priority I classification.

The Department states the Army has ordered a total of 2,304 Medical Corp Reserve Officers into Service since the beginning of the Korean fighting of which 1,264 are Priority I physicians.

### Dr. Meiling to Be Succeeded by Dr. Lovelace June 30

Richard L. Meiling, M. D., has resigned as Chairman of the Armed Forces Medical Policy Council, effective June 30, 1951.

Dr. Meiling, who is known by many of our members, has been on a two-year leave from his post in the Department of Obstetrics and Gynecology at the Ohio State Medical School.

Defense Secretary George Marshall said, in accepting Dr. Meiling's resignation, "You have ably discharged a difficult role in unification, and in developing a coordinated medical program for the Army, Navy and Air Force without loss of individual medical service independence which is necessary to the combat mission of each service."

W. Randolph Lovelace, II, M. D., Albuquerque, N. M., a member of the Committee, will succeed Dr. Meiling. Dr. Lovelace served as a Colonel in the Air Force during World War II, and is a diplomate in the American Board of Surgery.

## President's Page

The preamble to our Constitution is an excellent expression of our purpose as an Association and may well be recounted here.

"The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge, and to the advancement of medical science, to the elevation of the standard of medical education and to the enactment and enforcement of just medical laws; to the promotion of friendly intercourse among physicians and to the guarding and fostering of their material interest and to the enlightenment and direction of public opinion in regard to the great problem of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life."

Mr. J. P. Sanford lately suggested that thought should be given to the tabulation of a brief statement of the objectives of the State Medical Association which might serve as a goal for all members and as a guide for the central office. Like many of his constructive proposals this one appealed to the Council as meritorious, and

it was directed that such a document be prepared. This is being done.

We tend to conduct ourselves well as individual physicians but to neglect organized, concerted effort toward the public welfare or even for our own good. The people generally look to the medical profession for leadership in matters of health. We have been charged by various persons and groups,—and some quite sympathetic and friendly toward us,—with having neglected to offer a constructive and comprehensive program toward this end. To do so will inspire greater confidence and cooperation among the public generally and will enlist the united effort of our profession.

Education of more doctors and nurses, the medical care of the indigent, improved control of tuberculosis, better provision for the mentally ill, extension of the benefits of our Public Health program, enlightenment of the public in medical affairs—these and other problems of equal importance press us for solution. To formulate and facilitate plans and to lead the people toward their accomplishment is really our responsibility. It cannot be done by individual effort alone. Let us avail ourselves of the advantages derived from unity of purpose and action. Let us provide the strong leadership our citizens desire.

*Sam a. Overstreet*

PRESIDENT



# County Society Reports

## SCOTT

The Scott County Medical Society held its regular monthly meeting at the John Graves Ford Memorial Hospital on Thursday, April 5, 1951. The following members were present: Drs. W. S. Allphin, L. F. Heath, E. C. Barlow, F. W. Wilt, H. G. Wells and H. V. Johnson.

Mr. Porter Nunnelley, Mr. J. C. McKnight, Mr. Bryan Wolfe, Mr. Anson Burlingame and Mrs. Preston Morris, members of the hospital board, met with the Society.

Dr. F. W. Wilt urged that all records of patients be filled out before going to surgery.

Mr. Porter Nunnelley, Chairman of the Hospital Board, made a talk on the Hospital and urged that we have more cooperation between the Medical Society and the Hospital which will bring in more patients and come nearer putting the Hospital on a sound financial basis. His talk was followed by a round table discussion by every one present and we all were unanimous in thinking we should have better cooperation.

There being no further business the meeting adjourned.

H. V. Johnson, Secretary

## SHELBY-OLDHAM

The March meeting of the Shelby-Oldham Medical Society was on the 22nd, Dr. C. Wyatt Norvell entertaining with dinner at the Stone Inn.

The following members and guests were present: Drs. C. W. Norvell, L. B. Sternberg, S. B. May, George Perrine, A. C. Weakley, L. A. Wahle, M. D. Klein, C. C. Risk, C. O. Bruce and Colonel H. W. Daine, chief of Medical Service at Fort Knox, Dr. C. J. Gillooly of the State Board of Health.

After the dinner Dr. Norvell acted for the president, who was absent. The minutes of the last meeting was read and approved. The Secretary read a letter from Dr. Pat R. Imes, Chairman of the Committee on Emergency Medical Service asking a committee be appointed from Shelby County. Drs. L. A. Wahle, County Health Officer, L. B. Sternberg and A. C. Weakley were appointed.

Dr. C. J. Gillooly of the State Board of Health gave a talk on using sodium fluoride in the drinking water to prevent dental caries. There was some discussion and the Society went on record as in favor of this plan. Dr. Gillooly stated before this could be adopted it would have to be approved by both the dental and medical societies.

At this time Dr. Norvell introduced Dr. Daniel Costigan of Louisville who gave a very interesting talk on Fractures of the Wrist and Fore Arm. His talk was well discussed by all present.

Meeting adjourned at 10 P. M. The next meeting will be on Thursday, April 26th when Dr. George Perrine will be the host.

C. C. Risk, Secretary

## WARREN-EDMONSON

The March meeting of the Warren-Edmonton County Medical Society took place March 13th, at 7:00 P. M. at the Helm Hotel in Bowling Green.

The group endorsed the plan to add fluorine to the city water supply as recommended by the local Dental Group.

A committee was appointed to work out a call system through the hospital, publicize same in order to insure the availability of a doctor for all emergencies.

Dr. G. Y. Graves was elected as Director of the Warren County Cancer Clinic to fill the vacancy created by Dr. John Blackburn's death. Dr. Jess Funk was elected Assistant Director.

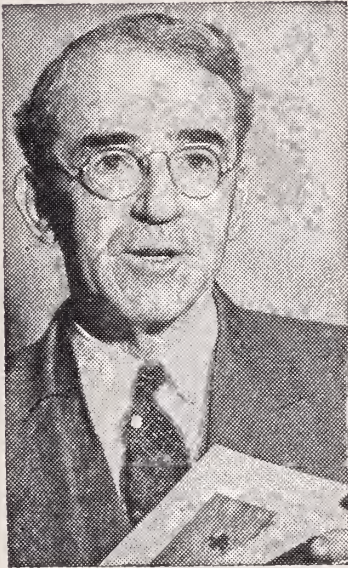
A committee was appointed to frame a resolution concerning the death of Dr. John Blackburn.

Dr. Hoy Newman issued an invitation to the group to be his guests at the next meeting. This was accepted with enthusiasm.

Dr. Ben Fowler, a Nashville Orthopedist, gave an interesting and informative discussion of Disabling Back Pain. Dr. Travis Pugh gave an interesting talk on the use of the Barton Forceps.

Frank H. Moore, Secretary

## News Items



**FRANK M. GAINES, M. D.**

**Louisville**

Dr. Frank M. Gaines, Jr., Louisville, has been appointed as State director of hospitals and mental hygiene. Dr. Gaines was formerly Clinical Director, Norton's Infirmary psychiatric clinic. He succeeds Dr. A. M. Lyon who resigned to become director of Central State Hospital, Lakeland.

Dr. Gaines is a native of Carrollton and was graduated from the University of Louisville School of Medicine in 1941. He served in the Army Medical Corps for three years during World War II, with twenty months in Europe. He served his residency in psychiatry at General Hospital and was a consultant in psychiatry at Central State. He did postgraduate work in psychiatry at New York Hospital.

Lt. (jg) James H. Stewart, Denton, serving in Korea with the Navy, received the bronze star February 19, 1951 for skill, excellent surgical judgment, personal sacrifice, bravery, endurance, saving countless lives. Lt. Stewart is a graduate of the University of Kentucky and received his M. D. degree at Tulane University, New Orleans, Louisiana and before being called into service, was studying surgery at Touro Infirmary in New Orleans.

Dr. Dale Maurice Royalty has opened an office in Lexington, for the practice of General and Reconstructive Surgery and will be associated with Dr. Howard E. Dorton and Dr. Jack G. Webb. Dr. Royalty, a native of Har-

rodsburg, Kentucky, graduated from Centre College in 1938 where he was a member of Phi Delta Theta Social Fraternity and an outstanding athlete. He graduated from the University of Louisville School of Medicine in 1942, interned at Grady Hospital in Atlanta, Georgia, served with U. S. Navy Medical Corps during World War II for more than three years as a flight surgeon. He received his training in Surgery at the Nichols General Hospital, Louisville, and at the Lahey Clinic, Boston, Massachusetts. Dr. Royalty was formerly associate instructor in Surgery at the University of Louisville School of Medicine. At the Lahey Clinic he was first assistant to Drs. Frank Lahey and Richard Cattell, two of the country's foremost surgeons. Dr. Loyalty has fulfilled the training requirements for the American Board of Surgery and Fellow American College of Surgeons.

A public ceremony marked the laying of the corner stone of the Allen Memorial Hospital, Scottsville, March 14. The special guests during the ceremony were friends of the service men who gave their lives in World Wars I and II.

The contents of the corner stone box contained among other memorials a list of Allen county War dead.

Dr. J. Luther Fuller, formerly associated with Dr. E. L. Henderson, announces the removal of his office to Suite 618 Francis Building; practice limited to general surgery.

Dr. Fuller was graduated from the University of Louisville School of Medicine in 1938. He served a one year internship at University Hospital, Oklahoma City, and a five year internship in surgery at Louisville General Hospital. He served for two years with the Naval Air Force in the South Pacific during World War II.

Dr. Fuller is a member of the American Board of Surgeons, American College of Surgeons and Southeastern Surgical Congress.

Dr. Clifford E. Harkey, a native of Graves county, has retired as staff physician at Fort Roots Veterans Hospital after thirty-three years of service.

Dr. Harkey was graduated from Western State Teachers College in 1903 and received his M. D. degree from the University of Louisville Medical Department in 1906. During World War I, Dr. Harkey served as Medical Corps



captain in France. Following World War I, he was with the United States Public Health Service, St. Paul, Minn., from 1921 to 1924. He became a member of the Fort Roots Hospital staff in 1941 after serving with Veterans Administration hospitals in Lexington, St. Paul, Minn. and Fort Snelling, Minn.

Dr. Thomas Crume, Owensboro, was selected by the Kentucky Heart Association to attend a rheumatic fever clinic conducted by Yale University School of Medicine in New Haven, April 2-13. The clinic was held in New England because of the high incidence of rheumatic fever in that area. While at the clinic Dr. Crume studied and observed the effects of rheumatic fever upon young children.

Lt. Edward G. Byrne has arrived in Ashland from the Korean theater of war. After a forty-five day leave, the Navy doctor and his family will go to Jacksonville, Florida, where he is assigned to a naval hospital.

Lt. Byrne served in Korea with the Seventh Regiment of the First Marine Division and was among those evacuated from the Hungnam beachhead.

Dr. Bert E. Moore, Minnesota, has been appointed as the new medical director for the State Tuberculosis Hospital, Madisonville.

Dr. Moore is a native of Minnesota and served in the Army six years as a specialist in chest diseases and has had wide experience in various Tuberculosis Hospitals and comes well qualified for his present position.

Dr. Peteris Voldemars Rozentals, Latvia, has been appointed assistant at the State Tuberculosis Sanatorium, Madisonville. Dr. Rozentals comes well prepared, as he was graduated from the Faculty of Medicine of the University of Latvia.

The Weeter Clinical Laboratory announces the continuance of all types of Clinical Pathology and Tissue Diagnosis with Malcolm L. Barnes, M. D., Owner and Medical Director. Dr. Barnes is also Pathologist at Norton Infirmary.

Dr. Octavus Dulaney, Louisville, Eye, Ear, Nose and Throat surgeon, observed his golden anniversary in medicine. He was graduated from the University of Nashville School of Medicine, now a part of Vanderbilt University on March 29, 1901. Dr. Dulaney is still enjoying a wide practice in Louisville and re-

ceived many congratulations from his numerous friends.

Dr. A. A. Shaper has been released from active duty in the Naval Reserve. He was recalled in September 1950 and served six months on active duty, four of which were spent in Japan as Commissioner of a Fleet Mobile Epidemic Disease Control Unit. Dr. Shaper has resumed his practice at his former office, 107 Breckinridge Lane, St. Matthews.

Dr. L. E. Oliver, Covington, has taken over the office of the late Dr. J. M. Ryan. The doctor will be in for office and home calls after July 1. Dr. Oliver was graduated from the University of Louisville School of Medicine in 1950 and served his internship at St. Elizabeth Hospital, Covington, and is a native of Owen County.

## *In Memoriam*

**M. S. ALLEN, M. D.**

**Elizabethtown**

**1861 - 1951**

Dr. Martin S. Allen, Elizabethtown, died April 17, 1951. Dr. Allen had practiced medicine for fifty-two years until his retirement in 1937. A native of Meade county he began his practice in 1885 at Pitt's Point, Bullitt County. He then moved to Stithton, Hardin County, now a part of the Fort Knox military reservation. From 1918 until his retirement he practiced at St. Helens, Jefferson County. Dr. Allen estimated he delivered 2,800 babies during his years of practice. He was former Hardin County health officer, and was an active member of the Hardin County and the Jefferson County Medical Societies.

**OWEN E. EDDLEMANN, M. D.**

**Sharpe**

**1876 - 1951**

Dr. Owen E. Eddlemann, Sharpe, died March 8th at Riverside Hospital, Paducah. He was seventy-four years of age. Dr. Eddleman had been a practicing physician at Sharpe for nearly fifty years having moved there from Dongola, Illinois in 1902 and had practiced since that time.

Dr. Eddleman was a veteran of World War I and is a member of the American Medical Association.

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- • • a bland mass which is intimately miscible with the intestinal contents and is extended evenly throughout the digestive tract
- • • gentle stimulation of the bowel wall, initiating normal reflex peristalsis
- • • medium stools—not hard, not soft
- • • no irritation, straining, impaction and
- • • no interference with digestion or absorption of oil-soluble vitamins.

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**SEARLE**

RESEARCH IN THE SERVICE OF MEDICINE





JOHN W. McNABB, M. D.

Louisa

1895 - 1951

Dr. John W. McNabb, prominent Louisa physician, died February 13, 1951. Dr. McNabb, known and beloved throughout the county, had practiced medicine in Lawrence County for the past nineteen years.

Dr. McNabb was born in Bellville, Pennsylvania, August 13, 1895 and received his medical degree from the Medical College of Virginia, Richmond, in 1923. He served his internship at Memorial Hospital in Richmond.

Dr. McNabb was a member of the American Medical Association, the Southern Medical Association and the Kentucky State Medical Association.

JOHN W. HARNED, SR., M. D.

Hopkinsville

1876 - 1951

Dr. John W. Harned, Sr., died April 22nd of a heart ailment at the age of seventy-five in Hopkinsville where he had practiced medicine for forty-four years. Dr. Harned was graduated from the Kentucky School of Medicine, Louisville in 1897, and served on the local Selective Board during World War I and was re-appointed during World War II.

H. C. HILLIARD, M. D.

Paducah

1875 - 1951

Dr. H. C. Hilliard, a McCracken county physician for nearly a half century, died March 15, 1951, he was seventy-five years of age.

Dr. Hilliard was graduated from Cincinnati School of Medicine in 1900 and practiced at Clinton two years before moving to McCracken county.

## BOOK REVIEWS

**CANCER AS I SEE IT** by Henry W. Abelman, M. D. Practicing physician at the Illinois Masonic Hospital, Chicago, Illinois. Philosophical Library, Inc. New York, N. Y. Publishers. 1951. Price \$2.75.

This book offers a penetrating analysis of the unsolved riddle Cancer; the author has endeavored to show by successive steps the factors suggesting the germ-virus nature of the disease.

Many pioneers of the parasitic theory have made valuable contributions to the infectious nature of cancer; many of their observations coincide with the author's research findings, which throw a new light on Cancer. This is a book for the laity as well as the medical profession.

**DIABETES MELLITUS—Principles and Treatment:** By Garfield G. Duncan, M. D., Clinical Professor of Medicine, Jefferson Medical College; Director of Medical Division, Pennsylvania Hospital and the Benjamin Franklin Clinic, Philadelphia. 289 pages with 31 figures and 40 tables. Philadelphia and London: W. B. Saunders Company, 1951. Price \$5.75.

The objectives in preparing this volume have been twofold; first, to bring together and correlate up-to-date principles in the understanding of and in the treatment for diabetes mellitus and, second, to deal with this disease and its complications in such a manner that physicians and students may find herein a practicable and simplified outline of therapy.

In fulfilling these objectives it has been necessary to cover quite a wide range, touching on nearly every specialty in Internal Medicine, as well as making excursions into the fields of Physiology, Physiological Chemistry, Pathology, Surgery, and Dietetics. The author

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Detailed considerations are given to the many facets of therapy and a considerable section of the book has been devoted to the complications, chronic and acute, of diabetes.

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**THE LIFE OF DR. PETER FAYSSOUX**, of Charleston, S. C., by Chalmers G. Davidson, A. B. M. Davidson College, M. A. University of Chicago, M. A., Ph.D., Harvard University. Published by The Medical Association of South Carolina. Columbia. 1950. Price \$2.75.

The Huguenot Peter Fayssoux was typical of his generation in the many facets of his interests, a Revolutionary patriot, an outstanding "practitioner of physic," a leader in local statecraft and a Charleston personality of singular appeal.

As Surgeon-General and Chief Physician for the Southern hospital during the Revolution he contributed much to the morale and success of the patriot cause. As leader of the Anti-Federalists, the "States-righters" of their day, he espoused a lost cause and predicted the future better than he knew.

The Medical Association of South Carolina presents this biography of its first president with the assurance that the subject is worthy of the distinction of the published biography of a native-resident South Carolina physician.

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**HANDBOOK OF MEDICAL MANAGEMENT:** by Milton Chatton, A. B., M. D., Instructor in Medicine, University of California Medical School, San Francisco; Sheldon Margen, A. B., M. D., Clinical Instructor in Medicine, University of California Medical School; Henry D. Brainerd, A. B., M. D., Assistant Clinical Professor of Medicine and Pediatrics, University of California Medical School, Assistant Clinical Professor of Pediatrics, Stanford University School of Medicine, Physician in Charge, Isolation Division San Fran-

cisco Hospital. University Medical Publishers. Second Edition. 1951. Price \$3.00.

This handbook fills a need not only of the medical student, but the general practitioner. The second edition incorporates new and accepted advances, with a revision of most of the chapters. This volume has been increased by thirty-two pages and includes new material on ACTH and Cortisone therapy, endocrine disorders, electrolyte balance, antihistamine drugs, newer antibiotic drugs, vitamin B<sub>12</sub>, physical medicine and numerous other topics.

In keeping with the objective of maintaining this as a handbook, there has been a careful deletion of non essentials and outmoded data from the original text.

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**PHILOSOPHY FOR THE COMMON MAN:** by Heinrich F. Wolf. Philosophical Library, 15 East 40th Street, New York, New York. Publishers. 1950. Price \$3.50.

The author, a practicing physician, is able in this book to achieve what many much more ambitious treatises have failed to do, namely to discuss basic philosophic problems with only little use of academic terminology. His expositions are grounded in the realities of science. Underlying them are some of the principles of the Philosophy of As-If, propounded by Hans Vaihinger. This book is a testimonial to him, who as professor of philosophy at Halle endeared himself to many of his pupils.

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**HOSPITAL STAFF AND OFFICE MANUAL** by T. M. Larkowski, M. D., F. A. C. S., Professor of Clinical Surgery, Stritch School of Medicine, Loyola University, Chicago, Illinois and A. R. Rosanova, R. Ph., M. D., Clinical Instructor, University of Illinois Medical School, Chicago, Illinois. Romaine Pierson Publishers, Inc. Great Neck, N. Y. Price \$5.00.

The book provides ready and practical phases of practice so that the busy physician can have at his finger tips all essential hospital and office technics, laboratory procedures, diagnostic aids, practical therapeutics in all branches of medical science and what might be said a quick refresher in all common surgical operations. It has the advantage of being in a pocket size volume.

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## THE USE OF CAROB FLOUR IN GASTRO-INTESTINAL DISTURBANCES

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LOUISVILLE

Diarrhea, whatever its etiology, constitutes a grave danger to children of all ages. This is particularly true in young infants because of the rapid loss of fluid and electrolytes in the stools, the development of acidosis with its resultant tissue damage and a lowering of the general resistance. In spite of a tremendous amount of research on the etiology, chemistry and treatment of diarrhea, this disease still carries a very high mortality.

For the last quarter of a century physicians have been gradually getting away from the use of the adult hydrous diet and experimenting with a variety of materials in an attempt to prevent the severe loss of fluid and electrolytes. Such things as raw apples, bananas, vegetable broth and pectin in its many forms have been tried with varying success. Ramos<sup>1</sup> after the Spanish Civil War noticed that animals and healthy children eating the flour of the pod of the carob tree became constipated. He also noted that ingestion of large quantities of this material frequently resulted in actual intestinal obstruction. On this basis he used the carob flour in the treatment of diarrheas.

The carob tree is found in great abundance on the shores of the Mediterranean as well as along the coast of Southern Europe, Africa, and Asia. Its fruit is a pod 8 to 25 cm. in length, 2 to 4 cm. broad, and 5 to 10 cm. thick. The covering is very hard and woody while the pulp is yellow and somewhat sweet. The pulp of the pod is the substance used in this dis-

cussion. Its composition and action has been well described by R. Martin du Pan<sup>2</sup> in which he calls attention to its richness in lignin. The material used in the observations to be described is identical to that used by du Pan.

Varying mixtures of carob flour were fed to a group of children of all ages with diarrhea from many causes. This report is a preliminary impression of the value of this material together with a statement of our experience with its use so far as concentrations and methods of administration are concerned.

Seventy-five children ranging in age from 7 days to 12 years in the diarrheal units of the Louisville General Hospital and St. Joseph Infirmary were fed solutions of carob flour, varying in strength from 5 to 10 per cent. Twenty-five children received carob flour in their homes while suffering from diarrhea. This was administered by their mothers under the supervision of the author. The results from this group, as reported by the mothers, was, of course, not as reliable as those observations made on children in the hospitals.

It should be stated that the carob flour was used as an adjunct only in the treatment of diarrhea. Fluid and electrolyte replacement therapy, chemotherapy of various types, and other routine measures were employed basically. In no instance was carob flour used unless the diarrhea was present as a major problem in the disease. The carob flour was fed in varying dilutions, mixed with water and sweetened with saccharin,  $\frac{1}{4}$  gr. to an 8 oz. mixture, for 48 to 72 hours. After this the flour was incorporated into the formula

<sup>1</sup>The carob flour used in this study was supplied to us by the Nestle Company under their trade name of aroton.

<sup>2</sup>From the Departments of Pediatrics of the University of Louisville School of Medicine and St. Joseph's Infirmary.



and fed at regular specified intervals. After the formula was begun the water solution of carob flour was continued between feedings. This regime was followed throughout the hospital stay. In some instances a sufficient supply of the flour for 5 to 7 days was given to the mother to be continued at home.

After trial of many dilutions it was found most practical to use a 5% solution in children under 2 years of age and a 10% solution in those over 2 years of age. In early states of the illness when the fluid balance was inadequate or variable, the solutions were taken eagerly in almost unlimited quantities regardless of whether or not saccharin was added. When the fluid balance became more stable these solutions were taken with greater reluctance, and the use of saccharin at this stage was of great help in maintaining adequate fluid intake.

In all children treated in the hospital the results were classified as excellent or good except in three children. Two of these continued to have five to six semi-solid stools 5 to 8 days after the beginning of treatment. The third child of 18 months with diarrhea complicating severe pneumonia, died 72 hours after admission to the hospital in spite of intensive corrective therapy. The reports of the mothers on the home treatment were for the most part very enthusiastic. In all instances except two the parents thought the children so much improved that therapy was discontinued by the fifth day. In these two cases the mothers discontinued the use of the flour because they saw no improvement in the diarrhea. It should be pointed out that the cases treated at home were much less severe than those in the hospital, and this is probably reflected in the results described.

As stated above, the carob flour was used as a adjunct to other diarrheal ther-

apy, and in no way as a substitute. The stools changed character to a brownish color with a very distinct odor, quite different from the foul odor before administration of carob flour. The consistency was more uniform and less liquid. The stools gradually became more formed and if carob flour administration was kept up too long they even became so firm that they were passed with difficulty. In fact, early in the trial when more concentrated solutions were used, it became necessary to use enemas on several occasions because of constipation.

In those diarrheas due to parenteral infection, the response of the stools to carob flour did not take place until the infection was brought under control. The carob flour did reduce the number of stools preventing too rapid loss of water and electrolytes by bowel. This helped early correction of acidosis and tissue damage.

Regurgitation of the fluid or formula containing carob flour was fairly frequent, but this did not seem to influence the progress or the improvement of the stools. Carob flour in the vomitus and stools did cause a brownish staining of the bedding and clothes. The milk laboratory complained that the bottles became discolored. This was fairly well controlled by thorough cleansing of the bottle immediately after feeding. A certain amount of staining after prolonged use of the bottles could not be alleviated.

It is the opinion of the writer that carob flour as an adjunct in the treatment of diarrhea is of distinct benefit. It is felt that these preliminary observations are encouraging enough to warrant further and more detailed study. It is hoped that other groups will make similar observations.

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**"Coxsackie virus" is a newly discovered virus that causes a disease which is often mistaken for mild, non-paralytical polio. Drs. Robert G. Fischer (University of North Dakota School of Medicine) and Jerome T. Syverton (University of Minnesota School of Medicine) have demonstrated that the ordinary cock-**

**roach can become a carrier of the virus. They caught cockroaches and fixed them to corks in the laboratory. The roaches were then allowed to feed on tissue from mice that had died of Coxsackie virus infection. Excretions of the roaches were injected into newborn mice. Paralysis followed within one or two days.**

## THE USE AND ABUSE OF CEREBROSPINAL FLUID

Ephraim Roseman, M. D.

LOUISVILLE

It is a truism in clinical neurology that if one cannot make a satisfactory diagnosis from the history, the neurologic examination will usually only help to confuse the picture, and the laboratory work-up frequently adds to the chaos. Given an adequate history, an experienced clinician should be able to reach an exact anatomical diagnosis and a satisfactory prediction of the etiologic basis of the disease. Since, however, Medical Science seems to be rapidly approaching the stage of "laboratory doldrums," it would appear that it behooves the clinician to at least familiarize himself with some of these tests. One of the most abused of these laboratory procedures is the study of the cerebrospinal fluid (CSF).

### Indication For Puncture

Indications for the performance of lumbar or spinal puncture are legion. In short, these include any condition in which the physician suspects primary or secondary involvement of the central nervous system or its coverings. The contra-indications are few, indeed, if any. The only condition which precludes the use of this procedure is in the face of increase in intracranial pressure, such as indicated by the presence of edema of the optic discs. But, even under these circumstances, careful puncture may be done with the possible exception of clinical evidence of an expanding posterior fossa lesion.

The most common tests performed on the CSF include: (1) pressure and dynamic studies; (2) cytology, including quantitative report of red and white blood cells with a differential count, as well as the presence of any abnormal cells such as bacteria, yeast, etc.; (3) chemistry, including globulin (Pandy) estimation, total protein, sugar and chlorides; (4) bacteriological studies, including, where indicated, inoculation on special media; (5) serological studies including both quantitative and qualitative tests such as the Wassermann or Kolmer and Kahn; and (6) colloidal gold reaction.

### Cerebrospinal Fluid Dynamics

Spinal puncture should always be done with the patient in the lateral recumbent posture, so that an accurate evaluation of the pressure can be made. Both the initial and final pressures, after the removal of the requisite amount of fluid, should be recorded. There is no direct relationship between the rate of flow and CSF pressure. The rate of flow varies with the size of the bore of the needle, the viscosity of the spinal fluid (presence of many cells and high protein), the accuracy of the puncture, etc. Once the water manometers are attached the operators should wait for the pressure to stabilize and remove all possible tension such as anxiety and resultant overventilation, straining (e. g. compression of the abdomen by the knees), etc. Normal CSF pressure ranges from 70 to 180 mm. of water. Low values are usually of no great importance and are frequently seen in states of dehydration or malnutrition.

The test of Queckenstedt has been grossly maligned in the study of cerebrospinal fluid dynamics. He pointed out that in the presence of obstructive lesions of the spinal subarachnoid space the rise in CSF pressure which normally follows compression of the veins of the neck (mainly the internal jugulars) does not take place. Since the spinal subarachnoid space is the only place in which complete obstruction occurs it would follow then that the sole indication for the study of the dynamics of the CSF is in suspected cord lesions. Although Queckenstedt was primarily interested in the diagnosis of lateral venous sinus obstruction, unilateral jugular compression has no place in the estimation of spinal subarachnoid block.

The procedures to be used in the case of suspected spinal subarachnoid block are simple. First the operator should assure himself that the lumen of the needle in the subarachnoid space is free and not abutting against a nerve root or a strand of arachnoid or is not plugged with blood or subcutaneous tissue. This requires only to have the patient cough or strain or to apply abdominal compression. Coughing



will ordinarily cause a rise of CSF pressure of 10 to 50 mm. of water. Straining or abdominal compression can elevate the pressure from 100 to 500 mm. of water. In all instances there is usually a rapid rise and fall. Once assured that there is no mechanical block the crucial dynamics test can be made.

Bilateral jugular compression can elevate the CSF pressure to almost unlimited amounts. Usually a rise of at least 150 to 300 mm. in CSF pressure can be expected. Upon release, the pressure falls to the original level. However, there are several factors which may modify the response to manual bilateral jugular pressure. The average jugular venous pressure is 100 to 150 mm. of water. Yet, many individuals will compress hard enough not only to obstruct the jugulars but also the carotid arteries. Or, frequently, the trachea will be compressed with the resultant straining and false response to jugular compression. It has been found that when there is indication for the study of CSF dynamics, jugular compression can best be obtained by applying a cuff around the neck. Provided a cuff (e. g. blood pressure cuff) is applied correctly, more uniform pressure can then be utilized. If the cuff is then inflated to 40 mm. Hg (544 mm. of water) the response of the CSF pressure should approximate 500 mm. of water.

### Collection of CSF

Whenever possible, routine spinal fluid should be collected in at least three tubes and marked 1, 2 and 3. The first tube should contain 1 to 2 cc. of fluid. This should be analyzed cytologically and for the globulin reaction. Tube 2 is reserved for the chemical studies, including total protein, sugar and chlorides and need contain only 5 to 6 cc. The Wassermann (Kolmer or Kahn) and colloidal gold tests are done on tube 3 and usually require 4 to 5 cc.

If the fluid is clear and colorless only the following tests need be done routinely: cell count, globulin tests (Pandy or Ross-Jones), total protein, colloidal gold and Wassermann reaction (always done quantitatively when positive). Sugar and chloride estimation is indicated only in the presence of a pleocytosis. Routine analysis for these chemical constituents should be discouraged since they are costly and unnecessary. In the face of pleocytosis, sugar and chloride estimation is of

value to determine if meningitis is present and may aid in the indication of the type.

Spinal fluid should always be collected in sterile tubes with sterile rubber stoppers so that sterility may be maintained and spillage prevented. If the fluid is cloudy or purulent some of the fluid should be immediately examined for the sugar content. The other chemical tests can be performed later in a routine manner. Another tube should be examined immediately for cytological content, after thorough shaking. After counting, the remaining fluid is centrifuged and the sediment smeared on clean slides and appropriately stained (depending on cellular content) with Gram's stain and/or an acid fast stain as well as Wright's stain. Another tube should be kept in the incubator over night and can then be examined for pellicle formation and organisms, since the fluid itself is a good culture medium. A fourth tube should be sent to the bacteriological laboratory and inoculated in suitable media. Finally one tube should be reserved for the Wassermann and colloidal gold reactions.

### Cytology of CSF

The total number and differential character of the various cellular elements can be studied very simply. Unna's polychrome methylene blue has been found invaluable for this purpose. A few drops of this solution should be filtered before each use. It is imperative that the cells be counted immediately after withdrawal of the CSF. The polychrome solution is sucked up into the ordinary white blood cell pipette and then expelled. This forms a thin layer of stain and usually suffices to adequately stain both the red and white blood cells (as well as other organisms, e. g. yeast) and relieves one of the concern of considering the dilution factor. Cerebrospinal fluid is then sucked up into the pipette and then shaken for 30 to 60 seconds. A drop of this stained fluid is placed on the ordinary counting chamber and the number of cells in the entire ruled chamber computed (this comprises the total 9 large blocks used in counting the white cells in circulating blood). For accuracy the result should be multiplied by 10/9 since the counting chamber contains only 9/10 cmm. However, this is only a 10 per cent error which can be readily neglected. This is the number of cells per cubic millimeter. The total number of cells as well as the num-

ber of red and white blood cells, including the differentiation of the type of white cells, should always be noted. Using the Unna's stain the nuclei of the white cells appear light blue, and the cytoplasm is colorless and only faintly visible. The red blood cells appear slightly yellow. If there is a large number of white cells, further differentiation can be made by staining a smear of the sediment with Loeffler's methylene blue or Wright's stain.

If the presence of yeast organisms is suspected, the CSF can be stained with India ink. If tuberculous meningitis is considered as a diagnostic possibility, an acid fast stain on the smeared sediment should be made.

### Bloody CSF

The greatest abuse in the study of the CSF is involved in the question of bloody fluids. Whenever a bloody fluid is obtained by spinal (cisternal, ventricular) puncture, the first question to be answered is: "Is this blood due to my

puncture technique or is it due to bleeding on the part of the patient?" This question can and should always be answered. Secondly, it is important to know that, contrary to general opinion, bloody fluid can be studied as completely as non-bloody fluid. This is true regardless of the source of the blood. The only possible exception is when the fluid clots immediately, and in this instance the blood is almost invariably due to the operator. Table No. 1 indicates how a bloody tap may be differentiated from a subarachnoid hemorrhage. It also indicates what correcting factors, if any, need be made in the cytological, chemical, serological and colloidal gold reactions in the bloody CSF. The fluid is collected in at least three tubes and cell counts (total red, white and differential) are made on the first and last tubes, being sure to carefully admix each tube. All tubes then are mixed together and immediately centrifuged. The remaining studies can then be carried out on the supernatant fluid.

If bleeding does not continue it takes

TABLE I  
COMPARISON OF CEREBROSPINAL FLUID IN "BLOODY TAP" AND SUBARACHNOID HEMORRHAGE

	"Bloody Tap"	Subarachnoid Hemorrhage
Pressure	Often low	Usually high
Amount of blood	Varies in different tubes	Evenly admixed in all tubes
Clot	Present at times	Absent
Supernatant fluid	Colorless unless more than 100,000 RBC/cmm (due to serum).	Xanthochromic
RBC count	Decreasing in subsequent tubes, usually highest in first.	Evenly admixed, same in all tubes
WBC count	Ratio WBC/RBC in CSF is same as WBC/RBC in circulating blood. (1 WBC to 700 RBC—if RBC and WBC are normal in circulating blood).	Any increase in WBC above ratio WBC/RBC in circulating blood is due to presence of RBC in CSF which causes a leucocytic reaction.
Total protein (supernatant fluid)	Every 750 RBC carries 1 mgm. protein per cent in serum. Hence do total protein on supernatant fluid and subtract 1/3 mgm. per cent for every 750 RBC, to get actual total protein content of CSF before blood appeared.	
Sugar (supernatant fluid)	No essential change	No essential change
Chloride (supernatant fluid)	No essential change	No essential change
Colloidal gold (supernatant fluid)	Less than 20,000 RBC—little or no effect. More than 20,000 RBC—may produce mid and first zone changes.	
Wassermann (supernatant fluid)	Negative reaction is of value in excluding syphilis of CNS. Positive reaction may indicate contamination with serum Wassermann reagent; does not necessarily mean CNS syphilis.	



between 7 to 10 days for blood to clear from the CSF. Hence, in cases of puncture where the fluid is too bloody for suitable analysis diagnostic repuncture should be carried out only after this interval of time. It is important to note that it takes 750-1000 cells (RBC or WBC) to discolor or make the CSF specimen appear cloudy.

### Chemical Analysis of CSF

The four most common chemical tests performed on the CSF are globulin, total protein, sugar and chlorides. The first is a qualitative examination and the others are quantitative. Routinely, only the globulin and protein tests need be done. In the presence of cells, the sugar content should be estimated. If the cells are few in number (1000 or less) or, are predominantly lymphocytes, chloride determination is indicated. Chemical tests should be carried out on the supernatant portion of centrifuged fluid.

Usually a positive globulin test (Pandy or Ross-Jones) indicates an elevation of the total protein and vice versa. Any disease of the nervous system may produce an increase in the protein content, especially if there is involvement about the meninges or surfaces (e. g., cortical, ventricular). An increased protein is seen usually in diseases producing a pleocytosis, e. g., meningitis, neurosyphilis, poliomyelitis, etc. Where there are few or no cells (albumino-cytologic dissociation) one might suspect cord tumor, brain tumor, polyneuritis, myxedema, late stages of poliomyelitis, etc.

The methods of protein estimation are legion. However, it may be said that those methods depending upon the measurement of the volume of protein precipitated by various reagents are grossly inaccurate and should not be used. The best methods are those which can be estimated photometrically.

Decrease in the sugar content in the CSF is seen almost exclusively in purulent meningitides (e. g., meningococcic, streptococcic, etc.) and in such chronic meningitides as tuberculosis and yeast. The sugar is usually not decreased in other forms of lymphocytic meningitis. The low sugar content of fluids from patients with acute or subacute meningitis is due to the glycolytic action of the organisms present. The low sugar content in bloody CSF is due to the action of glycolytic ferments which are present in the blood admixed

with it. The sugar content may vary in such metabolic diseases as diabetes.

Because of the possible presence of glycolytic organisms or ferments, sugar estimations, when indicated, should be done immediately after removal of CSF. If conditions do not allow immediate sugar determination a crystal of thymol, which inhibits glycolytic action, should be placed in the tube and the whole kept in the ice box until the estimation can be carried out.

As a general rule, the CSF chloride content parallels the blood serum chloride content, and is decreased in the presence of fever or vomiting and increased only in impaired renal function. A CSF chloride content below 600 mgs. per 100 cc. CSF is almost diagnostic of tuberculous meningitis.

### Serology and Colloidal Gold Reaction of the CSF

The complement fixation tests for syphilis are the most desirable ones in the study of the CSF. The Wassermann reaction, or one of its modifications is always desirable. In the study of syphilis of the nervous system a quantitative (titered) test should always be done. In asymptomatic neurosyphilis the quantitative changes in the Wassermann tests may be the only signs indicating the effect of therapy.

Concerning the colloidal gold reactions, the less said about them the better. Most laboratories are too poorly equipped or too unreliable to give satisfactory readings. More misinformation has been dealt out as a result of poorly conceived and executed colloidal gold reactions. When first discovered, it was thought that the colloidal reaction was not only diagnostic of neurosyphilis, but could differentiate the various types of syphilitic involvement of the central nervous system. In effect, these tests have no specific diagnostic import and are indicative only of an abnormality in the protein content of the CSF. Hence, such terms as "paretic," "syphilitic" and "meningitic" curves are obsolete and misleading.

### Normal Findings in CSF

Normal findings for the more common tests carried out on the CSF are charted in Table II.

Table II—Normal CSF (lumbar fluid)  
 Appearance ..... Crystal clear, colorless  
 Pressure ..... 70-180 mm. CSF

Cell Count .....0-5 WBC per cmm.  
 Globulin (Pandy, Ross-Jones Tests)  
 .....Negative (no clouding)  
 Total Protein...15-45 mgm. per 100 cc. CSF  
 Chloride .....695-760 mgm. per 100 cc. CSF  
 Sugar .....50-100 mgm. per 100 cc. CSF  
 Wassermann .....Negative  
 Colloidal gold .....00000000000

### Conclusions

1. Indications and contraindications for spinal puncture are given.
2. The common uses and abuses of cerebrospinal fluid studies are indicated.
3. Normal values for CSF, as removed from the lumbar sac, are noted.

## COMPARATIVE VALUE OF PRECORDIAL ELECTRO-CARDIOGRAMS OBTAINED WITH CF AND V LEADS

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The V or unipolar lead was introduced by Wilson (1) to eliminate the distortion effect of the remote or "indifferent" bipolar limb electrode upon precordial electrocardiographic patterns. A detailed review of the literature indicates difference of opinion as to whether CF leads should be completely discarded and V leads be universally adopted.

### V Leads

There are many advocates for the V leads. Hecht (2) stressed the distortion effects of the extremity potentials in producing false "positives" in the CF leads. He showed in a series of normal subjects that the position of the reference electrode has a considerable effect upon the size and form of the normal precordial electrocardiogram. When a central terminal is employed, the distortion introduced by the reference electrode is eliminated or reduced to a minimum. An unusually large T wave in V<sub>f</sub> could cause an inverted T wave in Leads CF<sub>5</sub> and CF<sub>6</sub> in normal subjects. Patients with a tendency to right axis deviation and those without axis deviation will show more distortion in CF than in V leads. However, he further states that the distortion caused by the reference electrode may in exceptional cases be helpful and in such cases an electrode on one limb alone may

be preferable to the central terminal. Hayes and Tomayo (3) made a comparative study of different precordial leads in ten normals and 100 patients with different types of heart disease. Since in some normals, a downward P and a downward T were found in leads CF<sub>1</sub> to CF<sub>3</sub>, they regarded V leads as preferable. Graybiel and White (4) state that the V lead will prove the most satisfactory indifferent lead point for routine electrocardiography because it shows less potential variation than any single extremity and therefore is less likely to alter the form of the precordial curves. Bain and Redfern (5) found that 10 per cent of records with CR and CF leads showed appreciable distortion. Inverted T waves may be recorded in CF leads in vertical hearts owing to negative distortion from the left leg. S waves tend to be more negative in CF leads, and R waves more positive with the result that the balance of the series may be altered and left ventricular hypertrophy may be missing or diagnosed wrongly. They conclude that the unipolar method of Wilson appears to be accurate with narrow limits. Hull et al (6) discuss false abnormality of T waves in CF leads. They state that the change of potential at the extremity may be sufficiently great to distort the precordial electrocardiogram in such a way as to simulate or to mask an abnormality. This false abnormality in CF leads can occur



most likely in cases in which relatively large positive potentials are encountered at the left leg. This is shown in leads II and III by large upward deflections. In such cases the V leads are normal. Jaffe et al (7) state that V leads should be employed routinely since they are probably more reliable than the CF leads. They found that in obesity inverted T waves in CF leads in any position were not abnormal but that the V leads showed inverted T only in position I. They occasionally observed in other patients a false Q wave in CF leads. Dolgin et al (8) found that in the vast majority of cases it makes little difference whether the "indifferent" electrode is on the right arm, left arm, left leg, or attached to a central terminal as far as clinical interpretation is concerned. Differences were found in 5 per cent of the cases with a relatively small mean error. They claim that it is not possible to make a categorical statement as to the ideal location for the indifferent electrode. On theoretical grounds, CR, CL and CF are all equally undesirable since all are subject to the distorting effect of the potential of the indifferent electrode. The magnitude and variability of distortion are most pronounced in CF and CL leads which directly reflect changes in the anatomic position of the heart. But they state that if the central terminal can be shown to be relatively constant in potential and consistently more indifferent than the extremities, it will be the location of choice for the indifferent electrode. In a subsequent report from the same laboratory (9) it unequivocally states that the V leads are preferable to CR, CL, CF or CB connections as an indifferent electrode for recording chest leads. Cameron (10) studied precordial positions 1-6 of CR, CL, CF and V leads in 30 normal and 30 patients with various types of heart disease. He found, in the normal cases, that differences are usually most obvious in the 1 and 2 or 5 and 6 positions where the amplitude of the deflections is small and therefore more liable to noticeable distortion. They are also more obvious in P and T because (a) deflections are smaller and (b) duration is longer than in QRS. He concludes that the V leads are preferable because they always occupy an intermediate position between the extremes of the other precordial leads, i. e. distortion is reduced to a minimum. Leatham (11) who studied 500 patients including 100 controls states that the CF

lead should not be used in routine practice since it so often appears abnormal in health. Burch and Winsor (12) state that V leads are most accurate and should be employed generally. The Committee of the British Cardiac Society on Multiple Unipolar Leads (13) suggested that the use of bipolar chest leads CF be discontinued, since the distal electrode in the case of CF introduces an error that may be positive or negative depending on the position of the heart, and that unipolar V leads avoid this error.

### Comparative Value of V Leads

Contrary opinions are expressed as to the comparative value of the V leads. Kossman and Rader (14) found no clinically significant differences between CF and V leads. They studied only one normal individual and eight patients with heart disease. Wallace and Grossman (15) compared the precordial electrocardiograms recorded by V and CF leads in position 2, 4 and 5 to determine how different they were under various circumstances. They found that the few differences encountered between V and CF leads were minor and concluded that the V leads offer little if any diagnostic information not obtainable in CF leads. Cullen and Fischer (16) studied 25 cases of acute myocardial infarction using leads CF<sub>1</sub> and CR<sub>1</sub> and V<sub>4</sub>. No significant differences were found. The voltages were not the same but for clinical purposes they so closely resembled one another that they felt one indifferent electrode position to be as useful as another. An editorial in the New England Medical Journal states (17): "In the diagnosis of myocardial infarction, it is doubtful that unipolar electrocardiography possesses any great advantage over bipolar methods. In anterior infarctions, the standard bipolar limb leads and multiple precordial leads, either unipolar or bipolar, are likely to provide information of diagnostic value. For the diagnosis of posterior infarction, the physician must still lean heavily on standard bipolar limb leads." The Committee on Electrocardiography of the American Heart Association reported in June, 1950 (18) that it was not in complete agreement relative to the most desirable indifferent electrode.

The present report is a comparative study of CF and V precordial leads. A series of 400 electrocardiograms of unselected adults seen routinely in private practice were analyzed. The records

were taken with the patient in a recumbent position. The three standard leads, the three augmented unipolar extremity leads and precordial positions 1 through 6, using CF and V leads, were taken in each case. A statistical analysis of the cases was not attempted. Approximately 95 per cent of the records were similar. This is the same frequency reported by Dolgin et al (8). Types of electrocardiograms are illustrated in which the differences between CF and V leads are of clinical significance.

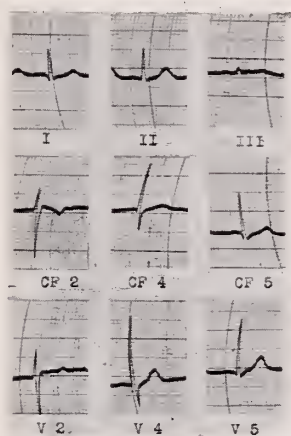


Fig. 1—Example in a normal individual of inversion of T wave in CF 2 but upright T wave in V 2.

### Normal Subjects

Figure 1 shows an example of inversion of T waves in CF<sub>2</sub> but upright T waves in V<sub>2</sub> in an individual with no evidence of heart disease. The appearance of so-called "false" abnormalities of the T wave in CF leads has influenced many physicians to abandon these leads. Confusion has arisen because the criteria for the normal CF leads presupposed that an inverted T wave, at least in positions 2 and beyond, was an abnormality. Larger series of normals have revealed that an inverted T in these positions of CF leads is not necessarily a sign of disease. Such inverted T waves in normal individuals are therefore not "false" abnormalities but are normal variants. They are not distortions but misinterpretations of normal precordial patterns.

In patients with hearts in a vertical electrical position there is a tendency for the CF leads to record relatively small R and large S waves in positions from the left precordium. The V leads in these positions have a more "normal" R/S ratio.

Also the T waves in the CF leads tend to be low and approach negativity. In the V leads the T waves are more positive. The resultant pattern might be confused with that of right ventricular hypertrophy. But the confusion is more apparent than real. This pattern has been stressed by other investigators (2, 5, 8).

### Anterior Myocardial Infarction

CF leads were of distinct advantage and superior to the V leads in numerous cases. Figure 2a is the tracing of a man with a recent anterolateral myocardial infarction, taken two hours after the onset of the pain. Only the CF leads show a characteristic pattern. One day later (Fig. 2b) V<sub>2</sub> and V<sub>3</sub> are abnormal but V<sub>5</sub> is still normal. Thirteen days later (Fig. 2c) both CF and V leads are abnormal and similar but a month after the onset of the infarction (Fig. 2d) the CF leads are still abnormal but V<sub>6</sub> and V<sub>6</sub> are normal. Figure 3a is another illustration of an electrocardiogram indicating an anterior wall myocardial infarction. In 3b, taken two years after the onset, CF<sub>5-6</sub> are abnormal but the corresponding V leads are normal.

The distinctive value of CF leads in the diagnosis of anterior myocardial infarction has been mentioned by several authors. Wolferth and Wood (19) incline to the use of CF as a routine lead, as compared to CR and CL, since cases of anterior infarction with healing or healed lesions are sometimes found in which the CF leads alone show T wave inversion. They admit that CF leads may show more "false positives" but that when the precordial electrode is placed over the apex, an inverted T in CF lead rarely occurs when the heart is normal. Graybiel and White (4) state that in a certain percentage of cases of anterior myocardial infarction, the diagnosis can be made from the precordial leads only. CF gives the least normal T when T-I is inverted or when all T's are upright. There is some advantage in using the most abnormal pattern, especially when T wave inversion is slight and is found in only one or two of the indifferent electrode connections. Bain and Redfern (5) illustrate an electrocardiogram of a patient recovering from a myocardial infarction. Leads V<sub>1</sub> and V<sub>2</sub> have negative T waves; T in V<sub>3</sub> is diphasic; T in V<sub>4</sub>-V<sub>6</sub> is positive but the T waves in CF<sub>1</sub>-CF<sub>6</sub> are negative. Jaffe et al (7) observed a case of coronary occlusion in which Q waves were only present



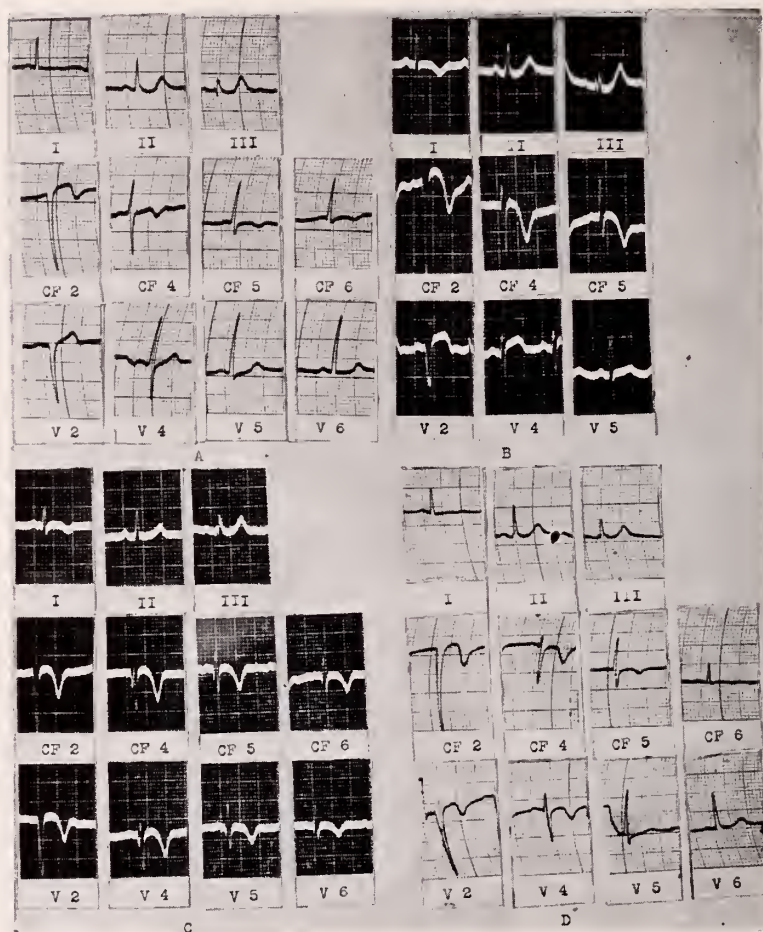


Fig. 2—(A) Records taken one hour after onset of antero-lateral myocardial infarction. Only the CF leads show a characteristic pattern. (B) One day later V 2 and V 4 are now abnormal but V 5 is still normal. (C) Thirteen days later, both CF and V leads are now abnormal. (D) A month after the onset, CF leads are abnormal but V 5 and V 6 are normal.

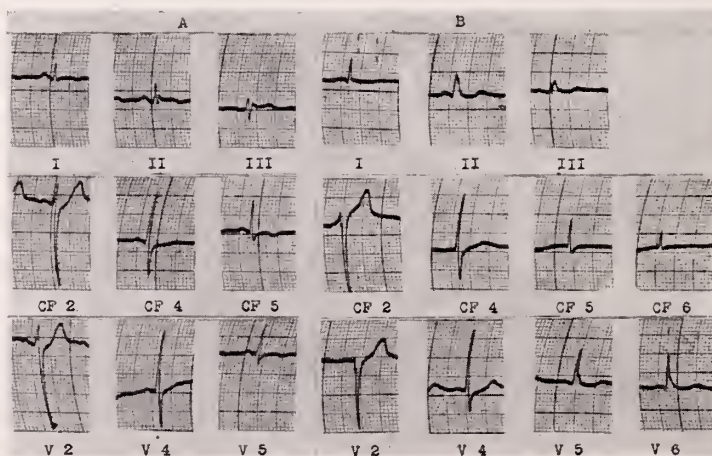


Fig. 3—(A) An example of antero-lateral infarction in which two years later (B) CF 5 and CF 6 are abnormal but the V leads are normal.

in the CF leads and occasional cases of acute hemorrhage in which T wave changes were present only in CF leads. Nagl (20) reported a case of angina pectoris in which the T waves were negative in CF<sub>2-5</sub> but positive in the corresponding V leads.

### Posterior Myocardial Infarction

Figure 4 is an example of an acute - postero - lateral myocardial infarction. It shows marked characteristic depression of the S-T interval in CF<sub>5-6</sub> but in the corresponding V leads only minimal depression of this segment is recorded. However, in Figure 5 which is another record indicating posterior wall infarction, the lateral extension of the lesion could be diagnosed only in V<sub>5-6</sub>. The CF leads fail to show this extension. Others have shown that CF leads from the left precordium may not show the lateral and anterior extension of a posterior wall myocardial infarction (8, 15, 21).

### RS-T Interval

Digitalis and acute coronary artery insufficiency cause depression of this portion of the ventricular complex. These effects, in occasional cases, were more evident in the V leads.

Since this paper was prepared for publication, two other articles have appeared:

Kistin, A. D. and Brill, W. D.: Clinically Significant Differences between Precordial Electrocardiograms Derived from V and CF leads, *Ann. Int. Med.* 33:636, 1950.

The authors conclude that the CF but not the V leads, can give false indications of cardiac disease.

Herrmann, G. R., Hejtmancik, M. R. and Kopecky, J. W.: Superiority of the Wilson Leads and the Value of Unipolar Limb and Precordial Derivations in Clinical Electrocardiography, *Am. Heart J.* 40: 680, 1950.

They state that the V leads are superior to the CF leads. False abnormalities may be obtained in CF leads. The pattern of uncomplicated posterior and posterolateral infarction is most conspicuously shown in V and usually missed in CF leads. However, the pattern of uncomplicated anterior infarction is most markedly shown

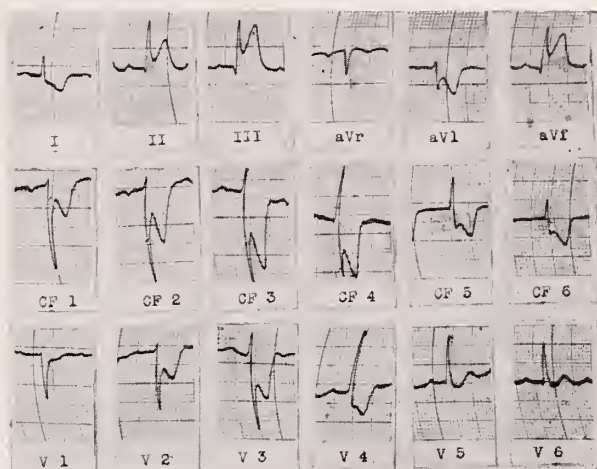


Fig. 4—An example of postero-lateral myocardial infarction with marked characteristic depression of the S-T interval in CF 5 and CF 6 but in corresponding V leads only minimal depression of S-T interval.

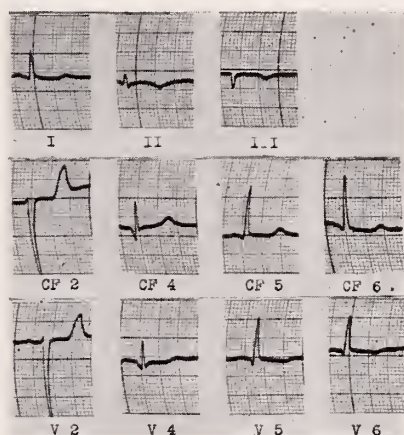


Fig. 5—An example of posterior wall myocardial infarction in which lateral involvement could be diagnosed only in V 5 and V 6.

in the CF leads, although these leads may exaggerate the extent of the lesion.

### Conclusion

CF leads furnish valuable information. They should not be completely discarded and V leads be universally adopted.

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## EXPANDING INDUSTRIAL HEALTH REQUIRES QUALIFIED PHYSICIANS

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We are all cognizant of the very rapid growth of industrialism in the South in recent years. This progress has brought, of course, many benefits. What is sometimes not fully realized is that it also has brought many new health problems, and that this in turn has created the need for better understanding of the whole field of industrial health by the physicians of the South.

### Responsibility of the Private Physician

This is especially true for the private practitioner because, at the present time, he has the responsibility for providing medical care and health maintenance to the great majority of employed people. It is obvious, in the light of these facts, that some means should be found to acquaint the private physician more fully with the health problems that arise in industry. He should have knowledge of the different phases of industrial health and know something of the occupational hazards and diseases to which his patients may be exposed.

To a large degree, the task of giving the practicing physician an understanding of industrial health should be one for the medical educators. The scope of this preliminary effort, of course, can greatly be expanded by work at the graduate level

and by additional training for the man already in practice.

### Opportunities Offered

For the undergraduate in medicine, a basic understanding of industrial health can be given by the inclusion of courses in the subject in the medical curriculum. For the medical man who wishes to specialize in industrial medicine, training, residencies, fellowships and in-plant medical department affiliation are available in the field of graduate studies. Industrial health institutes and post-graduate courses afford opportunities to the man already in practice, for acquiring the needed knowledge and techniques.

Already a good deal is being done about meeting these requirements. Most medical schools today have some provision for teaching industrial medicine to undergraduates. In a few schools this subject is being integrated with the courses taught in the pre-clinical years. And in most schools a formal course in industrial medicine is offered in the clinical period.

In a survey made by the Council on Industrial Health in 1947, a study of thirty-six medical schools showed that the time allotted for industrial medicine ranged from none to thirty-eight hours. This included both didactic lectures, field visits and demonstrations. In three-fourths of

the schools, the subject was given in the Department of Preventive Medicine and Public Health. It seems logical that the subject should be taught under this latter department because industrial medicine is so largely concerned with preventive medicine and community health.

### Description of Course

At the present time, industrial medicine is being given at the University of Louisville Medical School in the junior year, in fifteen weekly one-hour sessions. These fifteen sessions include lectures, visual material, demonstrations and presentation of cases. Lectures cover (1) objectives, organization, scope and facilities of industrial health services, (2) health hazards in industry and methods of control, (3) occupational diseases and accidents, (4) medico-legal aspects.

Demonstrations are given in the use of instruments for detection of toxic substances and of protective equipment used in industry. Additional time (six hours) is allotted for field visits to industries. These industries are selected for their employee health services and for the variety of hazardous processes which can be shown. The students are taken through the plants in groups of ten. It is believed that small groups, ten students or under, derive more benefit from these field trips than would larger groups.

Industrial medicine is introduced in the pre-clinical years at the Louisville school, as advocated by Dr. Leonard Goldwater. Material on occupational diseases and occupational health hazards is integrated in the courses in bacteriology, biochemistry, pharmacology, physiology and pathology in the first and second years. All this material serves as a background for the course in industrial medicine given in the junior year.

Since only a small number of medical graduates will become specialists in the field of industrial medicine, we can only hope to give the medical student a basic idea of what industrial medicine is and how it is related to the practice of medicine and to community health. However, recent figures from the American Medical Association, showing that full-time

physicians in industrial medicine increased from 345 in 1938, to 974 in 1949, an increase of 182 per cent, indicate the widening field for this kind of service.

### Requirements

For the physician who wishes to specialize in industrial medicine, a number of medical schools are offering courses ranging in length from one to three years. The Council on Industrial Health and the American Association of Industrial Physicians and Surgeons have given the following as the four essentials for residencies and fellowships in occupational medicine: health conservation, medicine and surgery, environmental hygiene and industrial medical administration.

For the physician already in practice who may or may not have had a course in industrial medicine, there are symposia, conferences and short refresher courses which can help him. These may be offered by medical schools or through local and State medical societies. There is a growing need for more of this type of preparation if the physician in private practice is to be enabled adequately to meet the health needs of industry. Recognition of this was made in Kentucky in the past year, when for the first time a speaker on industrial health was on the program at the Kentucky State Medical Association meeting.

The value of industrial health conferences for management should not be overlooked. When management understands the importance of a good industrial health program, it will seek the advice of competent physicians on health problems and this co-operation can go a long way in improving the level not only of the health in a given industry, but in the community as a whole.

Because industrial health problems become more and more a factor in community health in general, more meetings should be designed to reach management. Too many times meetings are held on industrial health only for those already engaged in this field. It is only through joint effort by the medical profession and industry that an adequate health service for the employed population can be provided under private auspices.

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**The creation of adequate medical service must** of necessity be the ultimate product of the working of many forces; enlightened local leadership, an informed and cooperative citizenry, a corps of well-trained doctors, and the financial

resources necessary to enable these doctors to earn a living and to establish and maintain efficient hospital services. Medicine in the Changing Order, Rep. N. Y. Academy of Med. Comm., The Commonwealth Fund.



## UNUSUAL ABDOMINAL FINDINGS SIMULATING ACUTE APPENDICITIS

### I. Primary Omental Torsion

### II. Solitary Diverticulitis of Cecum

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The acute abdomen presents a diagnostic problem usually solved by consideration of common lesions, but consideration of rarer lesions is a logical step when symptoms are ill defined. It is our hope that presentation of two cases of Primary Omental Torsion and a case of Solitary Diverticulitis of the Cecum may act as a reminder to the reader that these rare lesions are seen often enough for listing and are usually diagnosed as acute appendicitis preoperatively.

#### Primary Torsion of the Omentum

A review of the hospitals in Lexington revealed 314,469 admissions: St. Joseph Hospital 176,805 (1925 through 1949). Good Samaritan Hospital 137,664 (Jan. 1, 1929 through June 30, 1948) indexed, with two cases of Primary Torsion of the Omentum and two cases of Secondary Torsion of the Omentum. We are indebted to Dr. W. H. Pennington for permission to present briefly his case of Primary Torsion of the Omentum.

The frequency of Primary Torsion of the Great Omentum is low, as only seventy-three cases are recorded in the literature<sup>1,2</sup>. Eitel in 1899 reported the first case of primary intra-abdominal torsion occurring independently of secondary causes such as in hernia, or as a result of neoplasms, adhesive bands, or inflammatory processes<sup>1</sup>.

#### ETIOLOGY

Etiology is unknown and theories include obesity, trauma, hemodynamic changes in the omental vessels, rotary movements of the body, and the massaging effect of peristalsis<sup>3</sup>.

#### CLINICAL PICTURE

The clinical picture is indistinguishable from acute appendicitis for the presenting symptom of abdominal pain settling in the lower abdomen with nausea

and the rarity of the lesion leads one to omit mention of it in the differential diagnosis. The seventy-three cases known in the literature were reviewed and summarized recently<sup>1,2,3</sup>. The treatment is excision of the mass with ligation of the blood vessels. Only one death has been reported, and all emphasis is on recognition of this possibility when no other cause for the abdominal findings is evident. Altmeier and Holzer specifically state that in their six cases the surgeon had to palpate the right upper abdomen through the incision to find the small omental masses. In our case the torsion was massive.

#### CASE REPORTS

Case No. 1. (J.F.V.M.) E. W. 50-6523 (Adm. 3-20-50) Good Samaritan Hospital. Male; white; 48 yrs.; married. Onset fifty-three hours before admission after breakfast as an epigastric pain which slowly progressed into the lower abdomen, from the right to the left. He ate the day before admission without vomiting. Physical examination (T. 100.2, P. 104, R. 24) revealed an obese male not appearing acutely ill, with tenderness over the lower abdomen poorly localized, with rebound tenderness not referred. No mass.

Laboratory Findings. RBC 5,000,000; WBC 12,500; Hgb. 14.7 gm. 95%; C. I. 0.95; Differential Polys 79; Lymph 21; Stabs 19; Urinalysis negative except for 40-50 WBC per H.P.F. Four hours later the symptoms became more severe and the White Blood Count was 15,000, with 80% polys and 20% lymphs.

Preoperative diagnosis, acute appendicitis. Operative findings: The abdomen contained free fluid, and a large, thick, bluish-black mass presented, which proved to be omentum twisted clockwise three complete turns at the junction of the middle and upper thirds. The shrunken pathological specimen measured 30 x 35 cms.,

and was 6 cms. in depth at the thickest portion. The torsion neck was only 3 cms. in diameter, and was divided and ligated with two chromic catgut ligatures. The appendix was retrocecal, normal, and was removed. Convalescence was without event. Discharged on fifth postoperative day. The pathological diagnosis was apoplexy of the omentum showing much hemorrhage and vessel thrombosis.

Case No. 2. (W.H.P.) W.M.P. 52175 (Adm. 7-8-40) Good Samaritan Hospital. Male; white; 31 yrs.; married; Beer Distributor. Onset 7-5-40 with generalized abdominal pain which settled in lower right quadrant the following day, and accompanied by nausea. There was no vomiting, bowel movement, nor previous attack. Physical examination was negative except for tenderness over the lower right quadrant of the abdomen. Weight 190 lbs. He appeared at ease and in no distress.

#### LABORATORY FINDINGS

W.B.C 12,000; L. 17%; M. 4%; N. 79%. Urine acid, 1.027, amber, and negative for sugar and albumin.

Preoperative diagnosis, acute appendicitis, subsiding. Postoperative diagnosis, torsion of the omentum, primary. Operative findings: There was a complete 720 degree clockwise turn of the right leaf of the omentum with gangrene. The attachment to the normal omentum was ligated. Appendectomy. The pathology report is as follows:

Gross: The specimen consists of a large piece of strangulated omentum and the appendix. The omentum is firm and filled with extravasated blood. The appendix is grossly normal.

Histopathology: The sections from the omentum show inflammation on the surface with marked extravasation of blood throughout the tissue. There is slight diffuse lymphoid inflammation in the appendix.

Diagnosis: Chronic Diffuse Appendicitis. Strangulated Omentum.

Recovery was uneventful and the patient was discharged the eighth day.

The other two cases were secondary torsions associated in one case with an internal hernia above the hepatic flexure and in the other case with acute cholecystitis. Both patients recovered.

#### Diverticulum of the Cecum

The solitary diverticulum of the cecum was reported by Patier in the French literature in 1912, and only a few more than 100 cases have been reported since, mostly in the last ten years<sup>4</sup>. The average age of the ninety-nine patients was 39 years, this being a younger group than those previously studied for multiple diverticula. The sex ratio was 45 women to 47 men, whereas male preponderance is noted in multiple diverticulitis. In 94 recorded instances, the follow-up of the patient was given, there being 6 deaths, a 6.4% mortality rate. The pre-operative diagnosis was given in 63 cases as follows:

Acute appendicitis .....	43
Appendiceal abscess .....	6
Perforated appendicitis .....	2
Ruptured appendix .....	2
Degenerating fibroids .....	2
Salpingitis .....	2
Carcinomas .....	2
Diverticulitis .....	2

The choice of operation, as given in 96 cases, is as follows:

	Deaths	Mortality
Excision, 53 cases	2	4%
Rt. Colectomy, 18 cases	2	11%
Cececctomy, 14 cases	1	7%
Drainage, 5 cases	1	20%
Exteriorization, 2 cases	0	
Simple Closure, 3 cases	0	
Nothing, 1 case	0	

Bennet-Jones<sup>6</sup>, in 1937, reviewed 17 recorded cases and added 3 of his own. Busch and Friedfeld<sup>7</sup>, in 1942, found only 27 cases of proved solitary diverticula of the cecum, and noted that the lower right quadrant is the most common site of an acute surgical abdominal condition. Baker and Carlisle<sup>8</sup>, in 1943, stated that "about 37 cases are found in the American and British literature." Fairbanks and Rob<sup>9</sup>, in 1947, finding less than 60 cases in the English literature, could not find a single differentiating point between this and acute appendicitis. Gatewood<sup>10</sup>, 1945, found in his review that the only common symptom found in all cases was lower right quadrant tenderness.

#### REVIEW OF ADMISSIONS

A review of the 314,469 admissions to the two Lexington Hospitals brought to view one case of multiple diverticula



limited to the cecum and proximal ascending colon with symptoms referable to the lower right quadrant, but no case of a solitary diverticulum of the cecum was found.

#### ETIOLOGY

Etiology of the diverticulum is speculative, being primary (true or congenital) or secondary (false or acquired). Greenfelder and Hiller<sup>11</sup>, reviewing four cases found in surgical or autopsy material at the Michael Reese Hospital, emphasized the possibility of trauma being responsible for the development of the secondary diverticulum in one of the following ways:

- (1) Eversion of cecal wall between two constricting bands.
- (2) Traction by adhesions.
- (3) Eversion in cecal walls caused by a migration of a purse string suture into the lumen of the intestine.
- (4) Eversion of a weakened area in cecal wall resulting from rupturing into the cecum of an appendiceal stump abscess.

More recent reports classify them as follows: 9, 10, 11, 12, 13, 14, 15, 16, 17.

I. True or congenital diverticulum (mucosa, muscularis, and serosal layers).

II. False or acquired diverticulum (mucosal and serosal layers only).

#### OTHER FACTORS INVOLVED

Other factors such as obesity, constipation, weakness of the bowel wall, and intracolonic pressure are not applicable to development of the congenital solitary diverticulum of the cecum<sup>18</sup>.

#### CASE REPORT

Case Report History: (J.B.F.) S.D. 21 years; white; female; single. Referred on May 23, 1948, to the Sharon Heights Hospital, Jenkins, Kentucky, with the complaints of severe lower abdominal pain and tenderness with nausea and vomiting for two weeks. An appendectomy and bilateral salpingectomy had been done elsewhere two years previously because of the lower abdominal attacks of pain with no relief. During the attacks, there was a post prandial increase of pain and cramps, no particular type of food being

involved. Flatus and feces were "delayed" during these attacks, but obstipation was not present.

Physical Examination: BP 124/88, T 99.6, P. 115, R. 38. Negative except for the abdomen and pelvis, and a mild carpopedal spasm.

Abdomen: Marked tenderness and hyperesthesia in the lower right quadrant and suprapubically. No mass, no rigidity, no point tenderness, normal borborygmus.

Pelvic: Adnexa clear. Parametria tender, especially on the right, but most tenderness noted when the normal anterior fixed uterus was moved, with production of epigastric distress. Cervix clear.

Laboratory: Urinalysis (voided) clear, negative sugar, trace of albumin. Microscopic, negative.

CBC: RBC 4,550,000; Hgb. 88%; WBC 8,250; Diff. L. 22, M. 3, N. 67, E. 8. Blood type Ab, Rh positive.

The clinical impression of an acute surgical abdomen could not be verified by study at this time.

#### COURSE IN HOSPITAL

She vomited regularly after eating, and complained of cramping lower abdominal pain. Tap water in small amounts was retained. The continued lower right quadrant tenderness, worse with tensing the abdominal muscles, was very suggestive of intercostal neuralgia, and was relieved several hours with a 1% procaine block of the right 10th, 11th, and 12th intercostal nerves. She was discharged as slightly improved. At no time was peritoneal irritation or fever noted.

On June 5, 1948, she was readmitted with more severe pains in lower abdomen beginning three days before. No abdominal mass was palpable and peristalsis was normal. The marked lower right quadrant hyperesthesia was relieved again by a right 10th, 11th, and 12th intercostal block with 1% procaine. Her course in the hospital was one of continuous post prandial vomiting without distention, peritoneal irritation, or point tenderness. She was operated upon June 9, 1948, with a provisional diagnosis of intermittent small bowel obstruction. The omentum was adhered to the fundus of the uterus under tension, and division of the adhesion per-

mitted the uterus to "drop" into the pelvis. Exploration was negative except for the cecum which was thickened and presented a 2 centimeter indurated fluctuant diverticulum on its anterior medial aspect, 3 cm. from the appendiceal scar. The obstruction was easily corrected by displacing the fecalith digitally with decompression of the diverticulum. The concretion was removed and the diverticulum was inverted and closed with interrupted cotton. The diverticulum contained mucus and some purulent exudate. Recovery was uneventful.

Sigmoidoscopy on July 20, 1948, by Dr. O. T. Evans was reported "negative to 25 centimeters." A colon roentgenogram on July 21, 1949, by Dr. James Rich with air contrast revealed no evidence of diverticula. She has been comfortable during the two years after the operation and has eaten well, gained weight, and had no recurrence of any type of pain.

84% of these cases, as recorded, have the pre-operative diagnosis of acute appendicitis. Fecaliths play an important part in producing symptoms<sup>19</sup> and are found and described as present in from 47.75%<sup>17</sup> to 68.4%<sup>12</sup> of all cases. If an inflammatory mass is present, it is usually hard to distinguish from carcinoma.<sup>5, 6, 10, 13, 20, 21.</sup>

### Summary

Seventy-three cases of Primary Torsion of the Omentum and barely more than one hundred cases of a Solitary Diverticulum of the Cecum have been described and recorded.

The presented cases bear out certain conclusions reached in the literature. Each becomes a surgical lesion when symptoms or signs are noted.

Calcium, associated with phosphorus and magnesium, is the major mineral component of bones and teeth. It is also an essential constituent of all living cells, playing a part in regulating the cellular response to stimuli and the permeability of cell membranes. Deposits of calcium in the body structures give strength to the body's framework and act as a storehouse for the much smaller but vitally important quantities needed in the soft tissues and body fluids. In dietary deficiency, these deposits of calcium are slowly withdrawn and

Most cases presented clinical signs and symptoms of appendicitis.

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a severe depletion of the skeleton occurs before the effects of the deficiency become obvious.

Calcium is the single nutrient which was most frequently found to be deficient in dietary surveys conducted in United States cities in recent years. Low dietary intake of calcium is always associated with a low milk intake, for dairy foods (milk, cheese, and ice cream) supply about 75 per cent of the nation's available food calcium.



## TENDINITIS AND SUBACROMIAL BURSITIS

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Tendinitis and subacromial bursitis were poorly understood for many years until Dr. Codman of Boston explained in his writings that this condition was usually an inflammatory process secondary to some injury or calcium deposit in the supra spinatus tendon or other tendons in the musculotendinous cuff of the shoulder. It was he who proved by exploratory operations that the main etiologic factors could be attributed to some type of trauma to the supra spinatus tendon, either of the "wear and tear type" or due to a trauma of a direct nature. He theorized that this trauma caused a calcium deposit in the supra spinatus tendon, and when the calcium became superficial in the tendon then it caused an inflammatory process in the adjacent bursa. There is still confusion in the minds of some physicians as to the pathology and treatment of this condition, which results in a number of distressing and severely disabled shoulders.

### Subacromial Bursitis

Subacromial bursitis usually appears in a person past 40 years of age, but can occur at any age between 20 and 65. Statistics reveal that the condition occurs more often in females than males, and it may be that the male shoulder is equal to the trauma of unusual usage, so that it does not become affected as often.

A patient with early acute subacromial bursitis usually localizes the pain in the vicinity of the insertion of the deltoid muscle into the humerus. But one can find tenderness at this early stage by deep palpation in the region of the subacromial bursa. As the condition progresses discomfort involves the shoulder region. The individual may give a history of doing some type of unusual work with the shoulder as heavy work with a hoe or axe or shovel. He may have recently exerted his upper extremity in some sporting event or the arm might have been in some strained position while sleeping. As

the pain progresses voluntary splinting of the shoulder muscles causes the patient to hold the arm close to the side. The skin over the shoulder may become reddened at times, and usually there is excess swelling in the region of the subacromial bursa. Usually the pain is severe enough to require sedatives for partial relief.

Another group of individuals relate that their symptoms have come on slowly for days with increasing disability in the shoulder. Oftentimes these patients do not have a severely painful shoulder and they may have spasms of pain when the arm is rotated in external rotation or abduction, but at other times the shoulder may be quite free of pain. The subacromial bursitis with minimal symptoms except on usage frequently is seen by the physician with an extensive loss of motion in the shoulder. The more acute case usually consults a physician because it is necessary to have relief from the excessive pain and discomfort.

The acute shoulder when examined by X-ray will frequently present amorphous opaque masses from pinhead size to areas as large as the little finger in the region of the greater tuberosity of the humerus. In some the areas are separated. In others the X-ray is perfectly clear without any masses being visualized.

### Acute Bursitis

The acute bursitis case with severe shoulder pain that does not seek medical care usually subsides to a more sub acute stage in from 7 to 10 days time with resulting limitation of shoulder motion. Then pains begin to occur in the neck muscles on the involved side and at times radiate down the arm into the forearm. This is accompanied by generalized shoulder muscle atrophy. After several weeks time the condition passes into a more chronic stage with more muscular atrophy and very little shoulder motion. As time goes on shoulder girdle pain gradually becomes worse with radiation down to the arm, forearm and fingers. If the patient has access to opiates, and barbiturates by

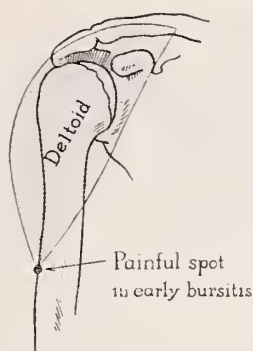


Figure 1—Diagram of shoulder and arm showing painful spot in early bursitis.

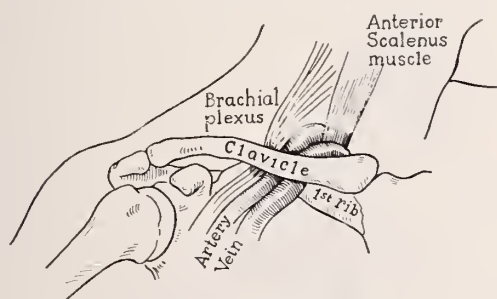


Fig. 2—Diagram illustrating the downward pull of an immobile shoulder in subacromial bursitis with brachial plexus compression causing pains radiating down into arm, forearm and hand.

this time he may become addicted to these medicines.

### Pathological Sequences

The pathological sequences found in the subacromial bursa can be explained by the theory that the whole process of tendinitis and bursitis starts with some minor type of injury to the musculo-tendinous cuff and a calcium deposit forms in the injured avascular tendinous fibers. As the calcium deposit enlarges it ruptures the covering tendinous fibers and pours its contents into the subacromial bursa. When the calcium deposit approaches the bursa acute symptoms develop and an acute inflammation develops in the bursal wall. With the emptying of the calcium contents into the bursal sack leukocytes are poured out and an excess of fluid formed. Then a fibro serous like material forms in the bursa and its walls become thickened resulting in an adhesive process. At times the inflammatory process is such that even the covering muscular fibers become reddened and in-

jected with an intense inflammatory reaction to the shoulder joint capsule as well. The calcareous type of deposits are not limited to the supra spinatus tendon alone but may be found in the infra spinatus, subscapularis and teres minor tendons. At first the deposit has a tooth-paste type of consistency and as the case becomes more chronic it becomes gritty with fibrous strands involving it.

In the more chronic subacromial bursal cases the X-ray films show changes in the underlying bone of the humerus. There may be seen a generalized osteoporosis or a dark area just beneath the greater tuberosity of the humerus may be the outstanding change. The osteoporosis may be the result of inflammation or due to lack of usage.

### Treatment

Conservative treatment usually suffices in the ordinary case of acute tendinitis and subacromial bursitis. Sedation is necessary because most patients have considerable pain and loss of sleep, and small doses of codeine or barbiturates are in order. However, in other cases larger doses of opiates are necessary.

The usual patient keeps his arm adducted to his side in order to splint it, and a measure which will relieve pain quickly is the placing of the arm on pillows away from the chest at 90 degrees or placing the arm on an abduction splint. Frequently this relieves pain in itself. Most patients use a sling and this adducted position if continued will cause stiffness of the shoulder. In some very acute shoulders bed rest is necessary due to the severe pain and disability.

### Hot Packs

Hot moist packs seem to be most beneficial for relief of pain and one should use them whether a patient is in bed or wearing an abduction splint, or keeps his arm abducted on the side of the bed or table. In very painful cases hot moist packs should be kept on 24 hours a day except when certain exercises are taken. In ambulatory cases that have mild pain novocaine injections of one or two per cent solution into the region of the bursa will temporarily relieve this pain and then circumduction and pendulum exercises can be started in order to bring about a complete range of motion in the shoulder. These exercises should be done hourly.



### Aspiration and Needling

Aspiration and needling of a calcium deposit after injection of novocaine is another popular method of treatment. Twenty to thirty cc. of novocaine are used in the painful area and a needle of sufficient size is introduced into the bursa in order to wash out and withdraw any contents. When the deposits are soft and of fluid type this is beneficial. After such an irrigation a shoulder manipulation should be done and the patient given instructions in circumduction exercises. This type of treatment is best carried out in a hospital because the pain returns after the needling and the patient should be near where plenty of sedation can be given. Cold packs are used for 24 hours and this should be followed by moist hot packs and the exercising routine. An exercise routine should be used in every case no matter what type of treatment has been used, and when resting, the arm should be placed in abduction, either on a splint or pillow. Pendulum exercises are easy to do and they are not contraindicated in any type of bursitis. After a few trials then the patient can do circumduction exercises and one should instruct them that the more they do them the sooner they will lose the pain. In the sitting position we try to have them put their hand behind their head to improve external rotation of the shoulder, and when standing they should place their hand behind their back for internal rotation of the arm.

### X-ray Therapy

X-ray therapy is beneficial to acute cases and some subacute cases. So often with the use of X-ray therapy the patient is not given exercises or hot packs. It is very necessary to use some type of heat and exercises following X-ray therapy or stiffness of the shoulder may ensue in spite of relief of pain. The acute symptoms of bursitis usually pass away in from 5 to 7 days and even after that the exercise routine must be kept up and the arm be abducted on a pillow while in bed. It is usually necessary to continue the circumduction exercises, placing the hand behind their head and behind their back for a period of several months time. It is well after the first week to use some dry heat in the form of infra red ray on the shoulder before exercising when possible. Until a normal range of motion has been established in the shoulder, exercises and even stretching of the tight shoulder is necessary.

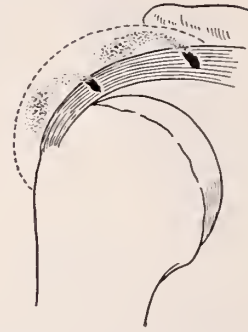


Fig 3—Diagram showing the rupturing of calcium deposits into the subacromial bursa.



Fig. 4—Diagram illustrating use of an abduction splint for relief of pain and to prevent an adducted still painful shoulder.

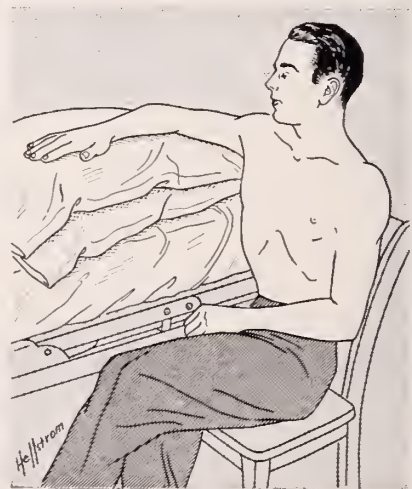


Fig. 5—Showing arm abducted on pillows of bed during treatment of subacromial bursitis.

### Indications For Surgery

Surgery is indicated in some cases of acute tendinitis with subacromial bursitis. Where large deposits are seen by X-ray quick relief from pain can be accomplished by surgery. Usually the only pain following surgery is that due to the incision. Patients with a sedentary occupation can be sent back to their jobs quickly following surgery. For men who do hard work a longer time is necessary for recovery. The larger the calcium deposit the greater the indication for surgery, but even with some small deposits and excess pain surgery is justifiable. At times some of the larger calcium deposits are not absorbed and a painful area remains in the bursal region.

At the time of surgery the shoulder is manipulated in all directions, and following the operation the arm is placed in an abducted position. Circumduction exercises and pendulum exercises are started within 24 hours and the patient is out of bed to do this. He is advised to sit beside his bed, keep his arm abducted on pillows and then put his hand behind his head when sitting down, and on standing to put his hand behind his back so that internal and external rotation can be promoted. Patients with subacute and chronic symptoms of bursitis extending over a period of 6 to 8 weeks usually have their arms immobilized to their side and thus present a more difficult problem to treat. At times they are very miserable persons due to pain and sometimes addiction to opiates

is present when the orthopedist sees the patient. X-rays may or may not present an opaque deposit in the subacromial region. Usually at this period they can not tolerate very much pain and they have to be handled gently. This type of patient should be near where he can receive physiotherapy twice a day, or he should enter a hospital for treatment. Then infra red heat or hot moist packs can be used to relieve pain so that exercises and stretching can be started. One must explain to these patients what has taken place in their shoulder with resulting adhesions and tightness in the tendons and muscles around the shoulder. They must be taught how to keep their arm away from their side on pillows or on an abduction splint. Pendulum exercises are begun gently at first and then more energetically later. Wall climbing and other exercises are instituted and by massage and gentle stretching over several weeks time the shoulder motion can be increased and pain will gradually be lost. As the shoulder loosens the patient becomes more free of pain. At times they have pains in the side of the neck radiating down the arm and forearm into the little finger. The immobile shoulder in such a case causes a stretching of the brachial plexus downward and produces this type of pain.

### Manipulation

Manipulation of shoulders in subacute and chronic bursitis cases under an anesthetic has been used at times. A com-

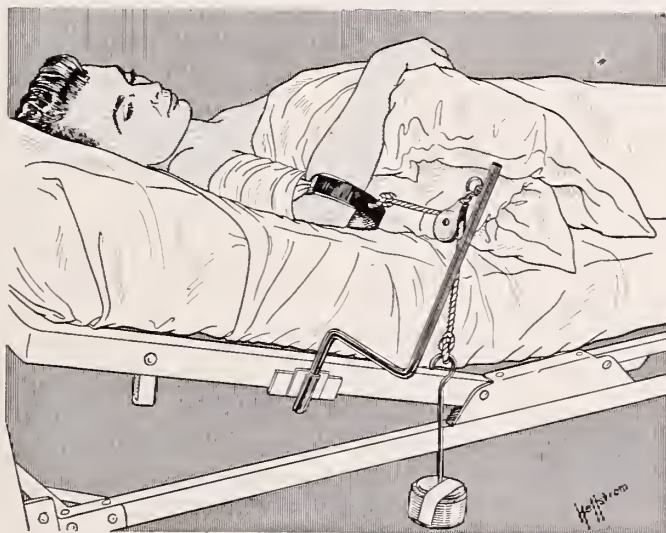


Fig. 6—Showing abduction traction in bed following irrigation or surgery for calcified deposits in tendinitis or bursitis.



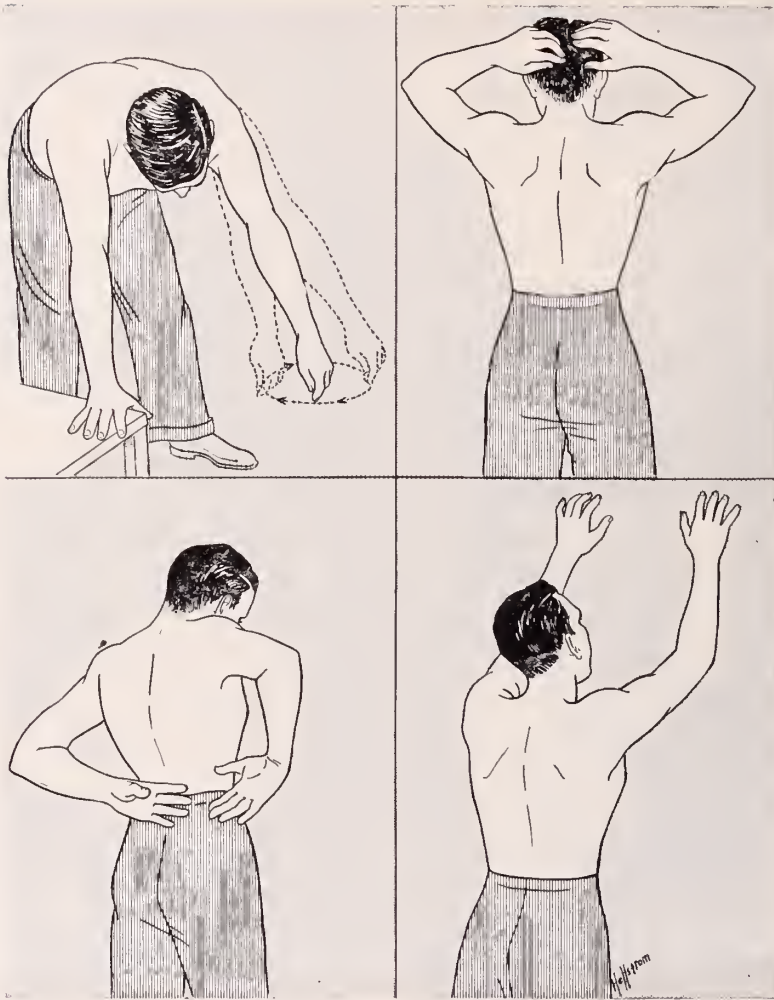


Fig. 7—Illustrations showing exercises to be used following all forms of treatment for subacromial bursitis; namely, pendulum and circumduction motions, external rotation stretching behind the head, internal stretching behind the back and wall crawling in elevation.

plete range of motion is sought by stretching the shoulder in several directions. Following the manipulation the patient has a great amount of pain, and an ice bag must be placed on the shoulder and the arm kept in an abducted position with traction on the arm. As soon as possible the patient must be assisted out of bed and exercises started. Then the patient can sit beside the bed and place the arm on pillows on the bed in an abducted position. At hourly periods pendulum and circumduction exercises are continued. Hot packs or infra red heat is used on the shoulder preliminary to the exercises for relief of pain. The exercises must be kept up energetically otherwise the shoulder stiffens just like it was before the manipulation.

Treatment of these hospital patients must be continued for several months following the manipulation. They should be in the hands of a competent physiotherapist and the physician should see them almost daily to impress upon them the necessity of hourly exercises and a heat routine at home. The more chronic patients will have to exercise sometimes for a period of 6 to 12 months before a complete range of motion has returned and the pain in the neck, hand and arm is relieved. A conscientious person can usually lose most of their pain in three to four weeks time in the more chronic cases.

#### Bilateral Bursitis

Bursitis in the region of the shoulder can be bilateral at the same time, but

more frequently patients may have symptoms in one shoulder at one period and maybe later on they will have pain in the other shoulder. Any bursitis patient should be cautioned against doing hard work and heavy labor until most of their symptoms have passed. There are painful shoulders due to chronic deposits remaining in the supra spinatus tendon. At times one may say they have only pain at night or when their shoulder cools off, but they have the pain from day to day. There are other patients who have residual calcium deposits seen on X-ray and are symptomless. The painful calcium deposits can be relieved by surgery.

### Pain Due to Other Conditions

Heart conditions, cervical discs, arthritis and superior lung lobe tumors at times cause persistent shoulder pain. A confusing situation arises when in these conditions a calcium deposit is present in the supra spinatus tendon.

### Summary and Conclusions

The nature of tendinitis and bursitis of the shoulder is such that with inadequate therapy a stiff disabled shoulder can result.

Usually conservative therapy with dry heat, moist packs and proper exercises will prevent the disabled shoulder.

The acute bursitis case needs to visit the physician almost daily to rehearse exercises and for him to impress the patient with the necessity of this.

Surgery at times is beneficial for acute and chronic patients.

Addiction in chronic cases is frequent.

### DISCUSSION

**Ernest E. Myers**, Lexington: In my discussion, I can only highlight some points of Dr. Fischer's comprehensive essay.

First, I can strike one optimistic note: One rarely sees a permanently stiff shoulder or a recurrence in the same shoulder. The most obstinate ones I ever had were those of a coronary thrombosis patient who had been nearly scared to death—not allowed to move his arms, even to eat. They were really stuck. Frequently, the trouble turns up in the other shoulder, which is only natural, since "frozen shoulder" usually occurs in a characteristic type. This is the high-strung, apprehensive, driving, impatient person; or else the big athlete grown soft, but still trying to build a house or lay a brick wall over a weekend. Rarely is it seen as an occupational

disease, as in plasterers or painters, acrobats or barbers, etc. In fact, one can almost diagnose the trouble by the type of patient as he walks into the office, holding on to an arm.

Whether the label attached is bursitis or tendonitis matters little, because treatment is essentially the same. The key is to recognize the particular phase the shoulder is in: "red-hot," acute, acute-subside, acute-ascending, or subacute. "Chronic" I reserve for that state in which there is residual limitation of motion but no pain.

Dr. Fischer has clearly discussed these phases, and the type of treatment has been well described; however, don't forget to treat the patient as a whole: one-quarter grain of phenobarbital, intelligent reassurance, plus hot, moist packs go a long way toward keeping him a patient rather than an impatient. Also, a word of caution may be sounded about overzealous exercising, particularly passive stretching. In my opinion, that had best be done under anesthesia, by the doctor himself.

That the patient should do the pendulum exercises with trunk bent at 90 degrees and all shoulder muscles relaxed, I am sure Dr. Fischer meant to stress. To induce this relaxation, it is helpful to give a few minutes of light, stroking massage over the shoulder girdle region while the patient is bent over. Also, if he holds a light weight in his hand, it is easier for him to get his arm swinging.

For relief of the "red-hot" acute case, we have found two-way irrigation through eighteen gauge needles most successful, and I believe it brings as prompt relief as surgery. Besides, one hates to scar a shoulder that might otherwise grace a strapless evening gown. An emergency traction thought up by one of my medical colleagues when he could get no comfort one night consisted of two belts, one looped around his wrist and one around his foot and tied together so that when he extended his leg, he could exert considerable traction on his shoulder through his arm.

I am not sympathetic with the old textbook edict of tying the hand to the head of the bed after manipulation. That jams the inflamed rotator cuff and bursa up under the overhanging acromion. As Dr. Fischer has so clearly pointed out, the secret is abduction with traction.

As he says, don't allow those frozen shoulders ever to become chronic, if you wish to avoid that long, slow disheartening pull back up the hill to normalcy.

I appreciate the opportunity to discuss Dr. Fischer's paper and congratulate him on its presentation.



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## CONGRATULATIONS TO COMMITTEE ON SCIENTIFIC ASSEMBLY

Since the Centennial Meeting celebrating a century of medical progress is expected to be the greatest meeting ever held by our Association and since its success will depend largely upon the quality of the scientific program, the Committee on Scientific Assembly was faced with a most important task.

That the Committee has done its job well is shown by the excellence of the program which is printed in the Organization Section of this issue of The Journal. It is a program that will be a tribute to our association and one of which a national organization could be proud.

Ordinarily our Scientific Assembly and the pages of our Journal are largely reserved to afford an opportunity of expression for Kentucky physicians. Even though the Committee has departed from this custom and no resident Kentuckian appears on the program of the Centennial Meeting, each speaker is either Kentucky born or received his medical education in Kentucky. Each has distinguished himself in the field of medicine in other states. We feel that the Committee has acted wisely in inviting these former Ken-

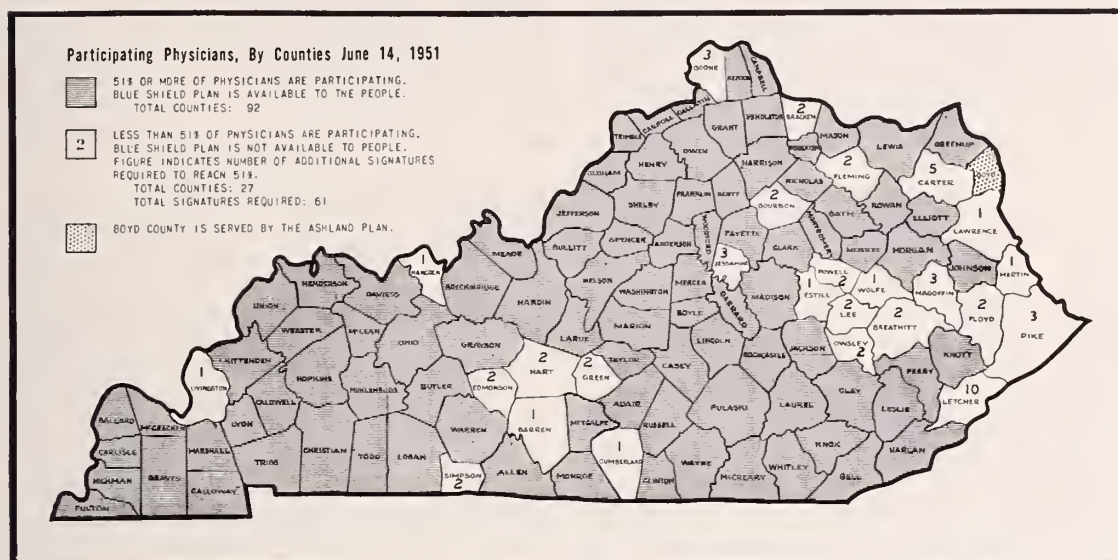
tuckians to return for our Centennial celebration. The result is an unusual array of talent.

We think the members of the Committee would quickly agree that the lion's share of the credit for this fine piece of work belongs to their Chairman, President Sam A. Overstreet. He has given the matter much thought, much time, and much hard work.

Dr. Overstreet said that the fact that these men welcomed the opportunity to come back to Kentucky and to renew old acquaintances was evidenced by the high percentage of acceptances of his invitations. Only a few who were asked were unable to appear on the program.

The President of our association is traditionally responsible for the Scientific program. The quality of this one will long redound to the credit of Dr. Overstreet. In addition to the president, the committee is composed of Drs. W. Clark Bailey, Harlan, Morris Flexner, Louisville, J. Duffy Hancock, Louisville, and the Secretary of the association. We extend to them our sincere congratulations.

# ERASURE OF GROUP MEMBERSHIP REQUIREMENT BROADENS SCOPE OF BLUE SHIELD AND BLUE CROSS



The Boards of Directors of Kentucky's Blue Shield and Blue Cross Plans have strengthened the bulwark against socialized medicine by making non-profit, surgical-medical-hospital insurance available to individuals who were not formerly eligible for membership because they were not members of an employed group. Any person who is 65 years of age or under and is in good health now has the opportunity to protect himself and his family by enrolling in the plans.

This action by the boards squelches the argument that voluntary health insurance cannot answer the problem of prepaying medical care because it is not available to farmers, workers in small businesses and many other individuals. About 1500 letters are on file which have been received from ineligible individuals in the past two years. Each of them will be written and informed that they may now enroll.

Increased utilization of the individual contract is to be expected. More poor risks will be included but, after all, persons who need protection the worst are those who are in need of medical care. However, in order to prevent disastrous results to the companies and to permit them to remain actuarially sound it is necessary to screen out applicants who are in immediate need of services so far as is possible. This can only be accomplished by careful underwriting based upon answers to a set of "health questions"

which are included in the application. It is also necessary to charge slightly higher rates in order to meet the costs of greater utilization. An enrollment fee of \$2.00 will be charged which will cover underwriting costs. The rates for the Blue Shield non-group contract are 25c more per month for an individual and 50c more per month for a family. The increase in Blue Cross rates are identical.

The new contracts will be sold through newspaper advertising which will carry a coupon to be clipped and mailed to the headquarters office requesting an application blank. Displays consisting of informative literature and business reply cards are being prepared for use in waiting rooms of participating physicians and in hospital lobbies. Contacting individuals by salesmen is entirely too expensive and would result in an enrollment charge that would be prohibitive.

The rule that the contracts will not be offered in any county unless at least 51% of practicing physicians participate remains unchanged. This means that the cooperation of the profession is even more important than ever before.

The present status of participating physicians is shown in the accompanying map. It may be seen that the majority of physicians in 92 counties have signed participating agreements and that very few signatures are required in the remaining 27 counties to allow the people



to enroll. It is interesting to note that practically all industrialized areas in the state are signed. Doctors in some of the unsigned counties have felt that there was no reason for their participation since the majority of their people were farmers or were self-employed and hence ineligible

for coverage. The issuance of individual contracts has completely changed this situation and it is believed and hoped that physicians will welcome this move which makes the plans attractive to the people and to the profession in all counties.

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## AMA BOARD OF TRUSTEES TO APPOINT LAY ADVISORY BOARD

The AMA Board of Trustees announced at the Annual Session at Atlantic City that it plans to appoint a committee of prominent laymen, representing industry, labor, agriculture, education, the bar and the clergy, to advise it in matters of medical care and "to present the viewpoint of the general public."

Dr. Louis H. Bauer, Chairman of the Board who made the announcement to the House of Delegates, said that he believed the committee would be one of the most important ever appointed because the men and women who serve on it "will be divorced from politics and will be serving unselfishly for the betterment of health and medical care for all the people."

This action of the Trustees gives the

consumer of medical care representation in the inner councils of medicine. It demonstrates at the national level the true interest that the individual physician has in his patient, both medically and economically. It permits the consumer to have a part in planning and problem solving. It will give the people an opportunity to learn of the many activities of AMA that are carried on for the purpose of maintaining the highest standards of medical care. Although the action stemmed from a desire on the part of medicine for a closer contact with the consumer, we believe it will result in excellent public relations by developing a mutually sympathetic understanding of common problems.

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## AN APOLOGY TO DRs. GAINES AND SMITH

We owe profuse apologies to Dr. Frank M. Gaines, newly appointed Director of Hospitals and Mental Hygiene of the Department of Welfare, and to Dr. L. E. Smith, retiring Executive Secretary of the Kentucky Tuberculosis Association.

A synchronized comedy of errors resulted in our using a cut of Dr. Smith labeled "Frank M. Gaines, M. D." in a news item. Since we do not wish to become involved in a discussion of which of the two gentlemen has a right to be more highly offended, we extend equal apologies to each.



FRANK M. GAINES, M. D.

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## EDITORIAL COMMENTS

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**Your contributions to the American Medical Education Foundation** have been ruled Federal income tax exempt by the Commissioner of Internal Revenue. This is another good reason for supporting this praiseworthy project.

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**Grants or loans for construction of hospitals in defense areas** may become available if the defense housing bill passes. Since several sections of the present housing law expire on June 30, early action is expected. The bill also authorizes the Federal government to operate the hospitals if the local government cannot or will not do so.

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**Many persons are engaged in trying to out-guess potential enemies of the United States** by foreseeing the effect of bacteriological warfare. One of the puzzles has been to determine what agents might be used. It has been suggested that a dangerous type of influenza might be introduced and this naturally raised the question as to whether or not a sufficient supply of vaccine could be prepared quickly enough to protect the people. The Public Health Service surveyed the situation. Dr. W. Palmer Dearing, Acting Surgeon General, has reported that their test operations have shown that a single laboratory can produce up to one million doses in five weeks. Granted early isolation of the new strain and cooperation of the industry, Dr. Dearing feels that a sufficient output could be expected to check an epidemic.

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**How can more doctors be secured for rural areas?** The simplest way, according to Dr. Harold S. Diehl, Medical Sciences Dean, University of Minnesota Medical School, is to recruit more medical students from rural areas. Speaking to the Congress on Medical Education and Licensure meeting in Chicago, Dr. Diehl pointed out that a survey of 545 graduates of Minnesota Medical School showed that the chances are two and one-half times as great that a student from a rural community will practice in a rural area as that a city boy will choose a location in the country.

The Board of Trustees of the Rural Kentucky Medical Scholarship Fund also feels that this is true. Although the

Fund's by-laws require that all participants practice in a rural area for as many years as they receive assistance, the ultimate aim is to select students who will be satisfied to remain after this obligation is repaid. Hence, the board favors applications from boys from rural homes.

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**The answer to stockpiling materials** to meet possible civil defense needs is not obvious. The original budget proposed for civil defense, which provided for stockpiling entirely at Federal expense has been drastically reduced. The House and Senate finally agreed to provide \$20,000,000 which must be matched by state funds. Since few states have made matching funds available and since state legislatures in most states have just completed their biannual sessions, it seems that the Nation will be ill-protected against the effects of atomic warfare.

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**"Survival Under Atomic Attack"** is the first of a series of official Civil Defense Administration films. It teaches individuals how to protect themselves. It is a 16 mm. film with sound and runs nine minutes. It may be obtained from the A.M.A. Committee on Motion Pictures for a service charge of one dollar plus transportation.

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**The Clinical Center, a 40 million dollar** addition to the National Institutes of Health, is expected to be completed in the latter part of 1952. Dr. Leonard Scheele, U. S. Public Health Service Surgeon General, described the Center as "the only combined laboratory-hospital in the world especially designed for research on a group of important chronic diseases—cancer, heart disease, mental, metabolic and neurological diseases, and blindness."

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**The American College of Chest Physicians** and the American Association of Industrial Physicians and Surgeons are seeking to obtain five million dollars from industry to finance research on the common cold. This condition is the most costly to industry of all illnesses in work days lost. The situation has not changed much since the day a lady asked Sir William Osler, "What do you take for a cold?" and he is said to have replied, "I take two weeks."



# ORGANIZATION SECTION

## K. S. M. A. And Five Other Groups To Stage Historical Exhibits

Five organizations have agreed to join with the Kentucky State Medical Association to present historical exhibits at the Centennial Meeting, depicting one hundred years of medical progress in Kentucky, William R. McCormack, M. D., Bowling Green, Chairman of the Centennial Subcommittee on Historical Exhibits, has announced.

The K.S.M.A. medical exhibit will be prepared by the Auxiliary to the State Medical Association. Mrs. Clark Bailey, Harlan, President of the State Auxiliary, will announce the personnel of her committee in the near future.

Other organizations participating, Dr. McCormack said, are the Kentucky State Dental Association, the Kentucky Pharmaceutical Association, the Kentucky State Association of Registered Nurses, the Kentucky Hospital Association and the State Department of Health.

The exhibits will be set up in two rooms at the right of the main entrance to the Columbia Auditorium, site of the Centennial Meeting.

## Committee To Nominate Candidates For State Offices Named

The Nominating Committee that will make nominations for the various K.S.M.A. offices and A.M.A. delegates that will be filled at the second session of the House of Delegates Wednesday evening, October 3, during the Centennial Meeting have been chosen, Hugh L. Houston, M. D., Murray, Speaker of the House of Delegates, has announced.

William L. Woolfolk, M. D., Owensboro, Chairman; Clyde C. Sparks, M. D., Ashland; and Joseph A. Bowen, M. D., Louisville, will make up the three man group. This Committee, Dr. Houston said, was selected by the President, President-elect and Speaker of the Association.

Chapter V, Section 5 of the By-laws provides: "The nominating committee shall nominate candidates for all offices except that of Councilors and shall make its report to the House of Delegates. Additional nominations may then be made from the floor by any member of the House of Delegates."

State offices to be filled are: President, President-elect, three Vice-presidents, Orator in Surgery and Orator in Medicine. Two delegates of the A.M.A. will be elected. One delegate for

a two-year term will be chosen to start January 1, 1952. A second delegate will be selected to serve from October 3 to January 1, 1952. The Association became eligible for a third delegate after the 1950 annual meeting as a result of a ruling of the A.M.A. at the Cleveland meeting last December. Following this ruling, Bruce Underwood, M. D., Louisville, was selected by the Council to serve until the next meeting of the House.

Two Councilors will be chosen at the October 3 session of the House. The terms of C. C. Howard, M. D., Glasgow, Councilor of the Fourth District and Edward B. Mersch, M. D., Covington, Councilor of the Eighth District, expire. Chapter V, Section 6 of the By-laws provides: "The Delegates from the counties in each Councilor District shall form the Nominating Committee for the purpose of nominating a Councilor for the Councilor District concerned." It also provides nominations may be made from the floor and that members of the District may attend the meeting of the Nominating Committee.



## Dr. Vance Presents Surgical Society With Unique Gavel

The gavel pictured above was presented to the Kentucky Surgical Society by Charles A. Vance, M. D., Lexington, the Society's first president, at the French Lick Meeting, May 19, 1951.

The gavel was made from wood collected by the late J. A. Stuckey, M. D., Lexington, from the first building of the Transylvania Medical College in Lexington, from the home of Ephraim McDowell, M. D., Danville, and a tree planted by Dr. McDowell in his backyard.

Three gavels were made from these three sources, one of which Dr. Vance had presented to the Southern Surgical Association and the other to the Southern Medical Association.

# SCIENTIFIC PROGRAM

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## THE EPHRAIM McDOWELL MEMORIAL MEETING

Celebrating 100 Years of Medical Progress

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### THE KENTUCKY STATE MEDICAL ASSOCIATION

LOUISVILLE, KENTUCKY

OCTOBER 2, 3, 4, 1951

Tuesday, October 2, 1951

9:00 Opening of Convention

9:15 "Injuries to the Ankle"

Robert P. Kelly, Emory University,  
Georgia

9:45 "Unilateral Upper Extremity Pain"

W. Gayle Crutchfield, Charlottesville,  
Virginia

10:15 Visit the Exhibits

10:45 "Some Physiological Considerations in  
the Treatment of Patients with Conges-  
tive Heart Failure"

Drew Luten, St. Louis, Missouri

11:15 "Oration in Medicine"

Carl Fortune, Lexington, Kentucky

11:45 Adjournment

1:00 Television—Medical Clinic

2:00 "The Use of Excision of the Head in the  
Treatment of Fracture of the Neck of the  
Femur"

Otho C. Hudson, Hempstead, Long Is-  
land, New York

2:30 "Surgical Treatment of Esophageal Hiatal  
Hernia"

Leonard Heaton, Major General, U. S.  
Army, Letterman General Hospital

3:00 Visit the Exhibits

3:30 "Infant Mortality as Related to the Three  
Leading Causes of Death"

Fred P. Helm, Austin, Texas

4:00 "Coeliac Disease"

William H. Wilson, New Haven, Con-  
necticut

4:30 Adjournment

Wednesday, October 3, 1951

8:00 Television—Surgical Clinic

10:00 "Why Anemia?"

Hugh Jeter, Oklahoma City, Oklahoma

10:30 Visit the Exhibits

11:00 "Human Injury from Atomic Explosion"

Elbert DeCoursey, Brig. General, U. S.  
Army, Washington, D. C.

11:30 "Oration in Surgery"

Charles Maguire, Louisville, Kentucky

12:00 Adjournment

12:30 Centennial Luncheon—"Kentucky, the  
Progenitor of Pioneer Doctors"

Lewis J. Moorman, Oklahoma City,  
Oklahoma

1:00 Television—Medical Clinic

2:00 "Hypogonadism and Infertility in the  
Male"

Henry Turner, Oklahoma City, Okla-  
homa

2:30 "Acute Surgical Abdomen"

Henry W. Cave, New York, New York

3:00 Visit the Exhibits

3:30 "The Diagnosis and Treatment of Aneu-  
rysms and Arterio Venous Fistulas"

Daniel C. Elkin, Emory University,  
Georgia

4:00 "Not in the Thing Itself"

Harry Beckman, Milwaukee, Wisconsin

4:30 "Doctors are Citizens Too"

R. B. Chrisman, Jr., Miami, Florida

5:00 Adjournment

Thursday, October 4, 1951

8:00 Television—Surgical Clinic

10:00 "Observation on the Occurrence of Tropi-  
cal Diseases in New Guinea, the Philip-  
pines, Japan, and Korea during and fol-  
lowing World War II"

Dwight M. Kuhns, Col., U. S. Army,  
Washington, D. C.

10:30 Visit the Exhibits

11:00 "Ulcer and Cancer of the Stomach"

Arthur W. Allen, Boston, Massachusetts

11:30 "Cortisone and ACTH in the Treatment  
of Chronic Arthritis"

Russell L. Cecil, New York, New York

12:00 Adjournment

1:00 Television—Medical Clinic

2:00 "Relapsing Pancreatitis"

Earl E. Gambill, Mayo Clinic, Roches-  
ter, Minnesota

2:30 "The Present Status of Cardiac Surgery"

Julian Johnson, Philadelphia, Pennsyl-  
vania



**3:00 Visit the Exhibits****3:30 "Angiography"**

Robert P. Ball, Cornell University,  
New York, New York

**4:00 "Deafness—Its Present Day Management"**

Arthur L. Juers, Miami, Florida

**4:30 Adjournment**


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**Licensed Interns, Residents Voted  
\$5.00 K. S. M. A. Membership**

Interns and residents who are licensed to practice in Kentucky and who are taking approved and recognized services in Kentucky hospitals may now join the Kentucky State Medical Association with full membership privileges upon the payment of an annual membership fee of \$5.00, provided the county society through which membership is sought will make a reduction in its annual dues charged the intern or resident.

This action was taken by the Council at its May 10 meeting because of its recognition of the limited income interns and residents receive and because of the desire of the Council to make available to them full membership in the Association and the privileges and services that go with it.

The intern-resident membership year will run from July 1 to June 30 each year. Non-licensed interns and residents in Kentucky hospitals may become associate members of the State Association at an annual fee of \$5.00. The associate membership includes a subscription to the Journal but does not provide for voting privileges.

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**Award Nominations To Be Submitted  
By August 30, Council Rules**

The deadline for submitting the nominations for the three Awards that will be made at the Public Meeting October 2, during the Centennial Meeting, will be August 30, the Council voted at its May 10 session.

Either an individual or county society may submit nominations for any of the three Awards described below, to the Headquarters Office. Following the recommendation of the Council, the House of Delegates will make the final decision at its October 1 meeting.

**The Distinguished Service Metal** - Awarded on the basis of the following points: (1) Contribution to organized medicine (including membership in county society, attendance county

and state, service on committees, as an officer, etc.). (2) Individual medical service. (3) Community health education and civic betterment. (4) Medical research. (5) Medical teaching. (6) Active military service. The applicant may qualify on any one, all, or any combination of these points. Reasons for the nomination should be clearly stated.

**E. M. Howard Award**—Given for outstanding service rendered in behalf of organized medicine.

**J. Watts Stovall Award**—Conferred on the general practitioner, adjudged the most outstanding in the state.

The information contained in your nominations should include, if possible, biographical data, professional accomplishments, civic and community interests and other interesting material.

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**State Officers To Speak At Ninth  
District Session July 13**

The new Ninth Councilor District has scheduled its first meeting for Friday, July 13, 1951, at Maysville, J. R. Cummings, M. D., Flemingsburg, Councilor, has announced.

"Medicine in Kentucky Today and Tomorrow" is the title of a discussion by Sam A. Overstreet, M. D., Louisville, president of the Association. Sharing the program with him will be Bruce Underwood, M. D., Louisville, secretary and general manager of the Association, who will talk on "The Responsibility of the Medical Profession."

Dr. Cummings said the meeting, which will be a dinner affair, will be held in the New Central Hotel in Maysville.

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**A. M. A. Moves Clinical Session To  
Los Angeles From Houston**

Los Angeles has been selected for the location of the 1951 Clinical Session of the American Medical Association, formerly scheduled for Houston, Texas, and will be held December 4 to 7.

The Board of Trustees of the A.M.A. moved the meeting after it was learned that the Coliseum in Houston would not be available due to a conflict in dates.

The Scientific Exhibits at the Clinical Session will be held in the Shrine Convention Hall.

## **Surgical Society Elects Dr. Thompson At French Lick Meeting**

Malcom D. Thompson, M. D., Louisville, was elected president of the Kentucky Surgical Society to succeed Pat R. Imes, M. D., Louisville, at the annual meeting of the Society in French Lick, May 19, according to an announcement of Francis M. Massie, M. D., Lexington, secretary.

Other developments at the French Lick session included the election of E. W. Jackson, M. D., Paducah, as vice-president, and the re-election of Dr. Massie as secretary. Lexington was chosen as the location of the 1952 meeting.

Henry W. Cave, M. D., New York, a native of Paducah and a graduate of Centre College, will be invited as the guest speaker for the 1952 session.

Arthur W. Allen, M. D., Boston and a native of Somerset, was the guest speaker at the French Lick Meeting. Dr. Allen was elected as an Honorary Fellow of the Society at the French Lick gathering.

In addition to Dr. Allen, four of the Society's members, Ernest E. Strode, M. D., Lexington, K. Armand Fischer, M. D., John S. Harter, M. D., and W. O. Johnson, M. D., all of Louisville, were on the scientific program to which sixty-six Kentucky physicians were invited.

During the business session, the Secretary reported the Society had fifty-four Fellows and two Senior Fellows. Following this statement, nineteen Kentucky surgeons were elected as new members. They are: Charles J. Armstrong, M. D., Lytle Atherton, M. D., John T. Bate, M. D., J. Andrew Bowen, M. D., Wm. H. Brown, M. D., J. Ray Bryant, M. D., Howell J. Davis, M. D., Leslie C. Dodson, M. D., Howard Dorton, M. D., Ellis Duncan, M. D., James C. Drye, M. D., Wm. M. Ewing, M. D., Clifton G. Follis, M. D., Joseph E. Maurer, M. D., Jacob M. Mayer, M. D., Wm R. Miner, M. D., Roy H. Moore, M. D., Alvin B. Ortner, M. D., W. V. Pierce, M. D., Virgil Powell, M. D., Clyde C. Sparks, M. D., Houston W. Shaw, M. D., and Gaithel L. Simpson, M. D.

## **Dr. Henderson Outlines Objectives In Presidential Speech**

"The medical profession has met the Socialistic threat with an accelerated, positive program designed to advance the health of the nation," Elmer L. Henderson, M. D., Louisville, told the House of Delegates in his Presidential Address delivered at Atlantic City, June 11, 1951.

Dr. Henderson said the objectives of the A. M. A. are to promote the national health through scientific activities, to foster and maintain high standards of medical practice and to solve health problems in a manner most conducive to the public welfare.

Among the long-term projects being carried on, he cited the following:

- Aid to medical education by raising funds from physicians, medical organizations and others in the field of medicine;

- Cooperation with other professional groups to meet the problems of hospital standardization;

- Promotion and development of voluntary health insurance;

- Establishment and effective use of grievance committees;

- Encouragement and aid in the establishment of night and emergency call systems, to assure 24-hour medical service in local communities;

- Development and operation of community health councils to solve health problems and improve local health facilities;

- Assurance of an adequate supply of properly trained physicians;

- Expansion of scientific activities which make the A.M.A. the focal point of American health progress;

- Working with employers and employees to reduce health hazard in industry; and

- Closer relationships between medical affairs and federal activities.

Dr. Henderson said, "As a final personal word—in my last formal address as your President—I want to say that it has been a great honor and stimulating experience to have been a leader in the American Medical Association during the recent past. And if I may steal a bit from the famous address of General MacArthur, I should like to say this, as an old soldier in the ranks of medicine; I do not intend to die very soon, and I do not intend to fade away; if the fight flares up again, I shall be glad to be a private in the rear ranks."

## **Rural Health Committee Leads In Forming Health Council**

Kentucky is to have a State Health Council, as a result of the efforts of the Committee on Rural Health of the Kentucky State Medical Association.

State agricultural, medical, dental, nursing, and health leaders, along with representatives of other state groups interested in the promotion of better health in rural communities in this state, met in the auditorium at 620 South



Third, Louisville, May 17, and voted to form the new state organization.

"Community health is the responsibility of the local community," Walter L. O'Nan, M. D., Chairman of the Committee on Rural Health, stated. He explained that it will be the function of the State Health Council to stimulate interest in, assist, and promote better health in the local counties through the coordinated efforts of member organizations of the council.

Many state medical associations in the South and Midwest, Dr. O'Nan pointed out, have made a most worthy contribution in assuming the leadership and responsibility for this movement. The A.M.A., through its Committee on Rural Health, is actively cooperating in assisting states interested, and sent its field representative here to work with our group.

At the May 17 meeting, a steering committee of seven was authorized. This committee, which plans to get together this month, will prepare the basic framework of the organization and make recommendations for projects for the larger group to consider.

### State Officers Urge Counties To Submit Delegate Lists

Forty-five counties have not submitted a certified list of delegates to represent them at the Annual Meeting, October 2, 3, and 4, to the Headquarters Office.

The officers of the Association are very anxious to receive this information and will be grateful to the societies listed below if they will give the matter early attention:

Adair	Jackson	Monroe
Anderson	Jessamine	Ohio
Ballard	Johnson	Owen
Boone	Latrel	Pendleton
Bracken	Lawrence	Perry
Breathitt	Lee	Pike
Calloway	Leslie	Powell
Carroll	Letcher	Pulaski
Clark	Lewis	Rockcastle
Clinton	Livingston	Rowan
Edmonson	Logan	Simpson
Grayson	McLean	Spencer
Hancock	Magoffin	Taylor
Hickman	Marshall	Warren
Hopkins	Martin	Wolfe

### Scholarship Fund Accepts 12 Making Total of 61 To Get Help

Eleven students who have been accepted as Freshmen at the University of Louisville School of Medicine and a Sophomore at Duke University School of Medicine were approved for initial loans to help finance their medical

education at a meeting of the Board of Trustees of the Rural Kentucky Medical Scholarship Fund in Louisville May 30.

Each student agrees to practice in a location in need of a doctor approved by the Trustees for at least one year for each year the student receives assistance from the Fund.

In addition to the twelve loans to the 1951 Freshman Class, the Fund is currently assisting 29 students in getting their medical education. A total of 61 students are now being, or have been, helped to get their education since the Fund began to operate.

A comprehensive report of an exhaustive study of counties needing more physicians was made by Raymond F. Dixon, Louisville, Assistant Secretary of the Fund.

Five Trustees whose terms of office had expired were re-elected. They are: John Walker Moore, M. D., Louisville; Tarleton Collier, Louisville; Carl Norfleet, M. D., Somerset; Charles B. Stacy, M. D., Pineville and Clarence Miller, Shelbyville.

The names of the twelve students to receive initial loans are: Marion A. Douglass, Jr., Middlesboro; William A. Johnson, Elizabethtown; Richard Natale, Louisville; Patrick A. O'Neill, Louisville; James A. Payne, Scottsville; Dwight L. Blackburn, Berea; Stephen Burkhart, Wallins Creek; Herbert Chaney, Pikeville; Sanford Radner, Brooklyn, N. Y.; Lon Edwards Roberts, Betsy Layne; Ronald O. Naser, Sturgis; and Si Alexander Past, Jr., Chattanooga, Tennessee.

### Technical Exhibits Are Carefully Selected By Committee

The technical exhibits at the Centennial Meeting in Louisville October 2, 3 and 4, may be visited by members of the Association with the assurance that space has been rented only to companies that have worthy products and who are entirely reliable, Carlisle R. Petty, M. D., Louisville, Chairman of the Committee on Technical Exhibits, stated.

Only those companies whose products, or services, meet the standards of the American Medical Association and who can advertise in the A. M. A. Journal are accepted. A number of companies cannot be taken each year because their products have not been approved.

The Technical Exhibits Committee urges each member to visit all of our technical exhibitions at the Centennial Meeting. This request is made not only because we should show this courtesy to the exhibitors who are making an important contribution to this expensive meeting through rents paid for space, Dr. Petty said,

but also because the information provided at these exhibits meets an intensely practical need of the doctors in their every day practice.

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### **Dr. Slucher Succeeds Dr. Gudex As K. A. G. P. President**

Richard R. Slucher, M. D., Buechel, assumed his duties as President of the Kentucky Chapter of the Academy of General Practice at the annual meeting of the chapter in Louisville, June 3.

Louis M. Krause, M. D., Baltimore, was the guest speaker at the session to which the wives were invited. The annual meeting is held each year the night before the University of Louisville-Kentucky State Medical Association Seminar gets under way.

Dr. Slucher succeeds Thomas V. Gudex, M.D., Louisville, as President. The other new officers, elected by mail and announced at the meeting, are as follows: President-elect, J. M. Bush, M. D., Mt. Sterling; Vice-President, Keith P. Smith, M. D., Corbin; Secretary-Treasurer, D. G. Miller, M. D., Morgantown; and Delegates to the American Academy of General Practice, Dr. Gudex and Dr. Daryl P. Harvey, Glasgow.

New Directors are: Vester A. Jackson, M. D., Clinton; J. Leland Tanner, M. D., Henderson; H. Burl Mack, M. D., Pewee Valley; Wilbur R. Houston, M. D., Erlanger; B. Ralph Wilson, M. D., Sharpsburg; W. E. Becknell, M. D., Manchester; Isadore M. Garred, Morehead; Price Sewell, Jr., M. D., Jackson, and Clark Bailey, M. D., Harlan.

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### **Dr. Schwerzman Honored At Covington**

A silver jubilee dinner honoring Arthur J. Schwerzman, M. D., Covington, was held at St. Elizabeth Hospital, Covington, and attended by the members of the staff and their wives.

Murray L. Rich, M. D., Covington, served as Toastmaster. Faculty and student nurses provided the entertainment at the dinner celebrating Dr. Schwerzman's twenty-five years as a member of the Hospital staff.

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### **Student A. M. A. Pleased With Results**

Officers of the University of Louisville Society of Student American Medical Association expressed themselves as being well pleased with the first few months of operation of this charter society of the Student A.M.A., Charles McGaff, President of the society, a Louisville sophomore, stated.

The local student group will not lose any members as a result of the June graduation, McGaff said. There are now 150 paid members

of this society and, with the incoming freshman class, the number is expected to go well over 200.

The society's president thanked the Council of the Kentucky State Medical Association for its cooperation and support. The Headquarters Office has endeavored to assist the student group in its organizational activities.

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### **Radiologists Form New Group**

The first tri-city radiological meeting, held under the sponsorship of the Kentucky Radiological Society, met Sunday, May 13, at the Seelbach Hotel in Louisville, John L. Dixon, M. D., Owensboro, President of the Kentucky Radiological Society, announced.

Harry M. Weber, M. D., of the Mayo Clinic, Rochester, Minnesota, was the principal speaker, and discussed "The Roentgenologic Examination of the Colon." Approximately 65 radiologists, from Indianapolis, Cincinnati, and Louisville, and surrounding territories, sat in on a two-hour film reading session in the afternoon.

"It is proposed that the group be maintained on an informal basis with no officers, dues, or other formal organization," the announcement said.

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### **President And Secretary Speak At County - District Meeting**

The combined meeting of the McCracken County Medical Society and the First Councilor District was held at the Ritz Hotel at 6:30 P. M., Wednesday, May 23, with W. P. Hall, M. D., presiding. There were 16 members and 13 guests present.

Sam Overstreet, M. D., President of K.S.M.A., gave a talk on "Medicine Today and Tomorrow." Bruce Underwood, M. D., Secretary and General Manager of K.S.M.A., spoke on "The Obligations of the Medical Profession." Mr. Ed Paxton, Jr., Paducah newspaper editor and Joe Sanford, Executive Assistant of K.S.M.A., were introduced.

Leon Higdon, M. D., made the motion that an autographed menu and flowers be sent to J. Vernon Pace, M. D., who had undergone an operation and could not attend the meeting. Dr. Pace, Councilor of the First District, had done much work in preparing the combined meeting.

The application of H. S. Gardner, M. D., was read to the Society and turned over to the board of censors. The same action was taken as last year for Diabetic Week with Robert Reeves, M. D., being chairman. The society approved payment of the guest dinners.



### K. S. M. A. Lists New Members

Following is a list of new members which the K.S.M.A. welcomes into the Association:

BELL: E. G. Lynch, M. D., Middlesboro

BOYD: Edward W. Connelly, M. D., Ashland;  
William Hoy, Jr., M. D., Ashland

CAMPBELL-KENTON: Edwin L. Higgins,  
M. D., Covington

CHRISTIAN: James H. Wells, M. D., Hopkinsville

FLOYD: J. E. McKinney, M. D., Wheelwright;  
Russell L. Hall, M. D., Wheelwright

HARLAN: David K. Davis, M. D., Verda;  
Lawrence U. Gilliam, M. D., Harlan; Hugh  
Hayes, M. D., Twila; James B. Jones, M. D.,  
Verda

HENDERSON: Clarence Harvey, M. D., Henderson

JACKSON: Arch B. Clark, M. D., McKee

Jefferson: Roxie T. Mudgett, M. D., Louisville;  
Charles E. Pearce, M. D., Louisville;  
Francis J. Smith, M. D., Louisville; Davis H.  
Vaughan, M. D., Louisville

LAUREL: John S. Wisely, M. D., London

LOGAN: E. B. Gudenkauf, M. D., Lewisburg

MADISON: E. T. Hays, Jr., M. D., Berea

McCRACKEN: Walker Turner, M. D., Paducah;  
Jesse M. Hunt, M. D., Kevil; Margaret  
B. Magruder, M. D., Paducah

McLEAN: Charles W. DeWeese, M. D., Livermore;  
B. C. Stigall, M. D., Livermore

PERRY: Ernest T. Anderson, M. D., Ary;  
Jack B. Mershon, M. D., Delphia.

## Pertinent Paragraphs

**Montgomery County Society members** were honored guests recently, at a dinner meeting of the Mt. Sterling Lions Club. At this special session, a club member made a talk on "What the Community Owes Its Physicians." It was announced that the meeting would become an annual affair.

**The National Industrial Medical Association's** annual Health Achievement Award was won by the C. T. Dearing Printing Company of Louisville, of which Gracie R. Rowntree, M. D., is medical service director. The Association's president, Edward H. Carleton, M. D., East Chicago, in presenting the award, said it was for "the year's outstanding job of providing employees with complete medical service." The award was made at the recent Atlanta meeting.

**The medical schools at the University of Tennessee and Vanderbilt** have added a course in medical ethics to their curricula. These courses have been started as a result of the efforts of the Tennessee State Medical Association. This was one of the points listed in the "Tennessee Ten," which is a statement of policy of the association.

**A full explanation of the new Public Law 28** covering benefits to which servicemen who went into service after the outbreak of the Korean conflict are entitled has been issued by the Veterans Administration. Many of the benefits provided by this law are allowed veterans even though the need for them was not due to active service under war conditions.

**The Woman's Auxiliary to the Muhlenberg County Medical Society**, for the second consecutive year, won third place in Group 2 of the nation-wide subscription promotion contest, sponsored by "Today's Health," a publication of the American Medical Association.

**The annual Veterans Administration report** indicated that 33% of all patients hospitalized in VA hospitals had service-connected disabilities. Only 12% of the general medical and surgical patients were service-connected. Schizophrenia patients constitute the largest single medical problem confronting the Veterans Administration.

**The sixth annual postgraduate course in diseases of the chest**, sponsored by the Council on Postgraduate Medical Education and the Illinois State Chapter of the American College of Chest Physicians, will be presented at the St. Clair Hotel, Chicago, Illinois, September 24-28, 1951. The course is open to all physicians but the number of registrants will be limited, and a tuition fee of \$50.00 will be charged. Applications will be accepted in the order received, and should be mailed to 112 East Chestnut Street, Chicago 11, Illinois.

**Approximately 92 physicians in central Kentucky** attended a course on the treatment of atomic illnesses at the Good Samaritan Hospital in Lexington, sponsored by the Fayette County Medical Society, on May 29. The Committee on Emergency Medical Service of the Kentucky State Medical Association, in cooperation with the State Civilian Defense organization, arranged the program. Gerald M. Peterson, M. D., Louisville radiologist, and George Benton Sanders, M. D., Louisville surgeon, gave the scientific papers. A film was included in the program.

# President's Page

This year marks the Centennial of the Kentucky State Medical Association. In preparing a fitting celebration we have tried to plan a few features fitting to the occasion and to spare the expense of elaborate and pointless ostentation. We hope first of all to take stock of our resources in medicine, to orient ourselves in the present world of progress—to unite our energies and begin to move forward into our new century with well planned and constructive objectives.

We honor, this year, Dr. Ephraim McDowell, Kentucky's eminent pioneer surgeon whose contribution to progress is acclaimed throughout the medical world. Dr. McDowell was born in Virginia but spent his professional life in Danville where his epochal operation was performed. He was never president of this body but we elected to commemorate him because he is regarded by many as our outstanding medical citizen of all time.

A list was compiled of sixty-eight physicians throughout the United States who had distinguished themselves outside Kentucky but who are natives of our state or received most of their medical education here. A selection of twenty-six of these men was made by the Committee on Scientific Assembly and invitations were extended to them to appear on our program. Twenty-four accepted. These men are leaders in their respective fields and the presentations they offer would, without exception, be creditable on any of the national programs we are accustomed to hear. The enthusiasm which they manifest at the opportunity to return and participate in our program is most heartening.

The only permanent token of our Centennial will be a commemorative volume containing the collected papers presented, together with a brief biographical sketch and perhaps the picture of the author. Dr. Emmet F. Horine has graciously agreed to add to this volume a brief biographical sketch of Dr. Ephraim McDowell and a short history of the Kentucky State Medical Association. Unfortunately we are not financially able to pre-

sent a volume to each member. We are endeavoring, however, to have it compiled in a handsome edition which every member will be proud to have and at a price he will be willing to pay. The support of the membership in this endeavor is essential to its success. It will be impossible to make delivery at the time of our meeting but orders will be taken there and its distribution will be effected as soon as possible thereafter.

Some physicians look forward to the scientific exhibits as the most helpful and interesting part of any medical convention. Much preparation for this part of our program has been made. The Council has been most liberal in appropriating funds to provide adequate and choice space and the Scientific Exhibits Committee is selecting an unusual variety of the very best material offered. Ample space, adequate lighting, and liberal time allowance for viewing these displays will highlight this feature.

Let us not forget that our commercial exhibitors largely underwrite the expense of our convention. They are our friends. They are the men from whom we buy our supplies, our equipment, our material, our books, and our drugs. They are the supporters of our recent campaign. They are the boys who wait patiently in our reception room for a five minute interview. They furnish us with an epitome of the latest in medical research and progress. They represent more than commercial houses and exhibitors. They celebrate with us a hundred years of growth and achievement. With them we will move forward in a new and brighter century. Meet them—give them the glad hand of fellowship—did you ever consider how difficult it might be without them?

Plan now to attend our Centennial—plan to stay through the entire program—every presentation will be worth while. Support our Centennial publication. Visit our exhibits. Let's begin the new century in a bond of true fellowship and in renewed consecration to our people and our profession.

SAM A. OVERSTREET, PRESIDENT



# County Society Reports

## JEFFERSON

The March meeting of the Jefferson County Medical Society was held Monday evening, March 19, 1951, at the Seelbach Hotel. There were 103 members and guests present for dinner, and at least 25 additional for the scientific program.

The meeting was called to order at 8 p. m. Dr. Lawrence Minish, Jr., Second Vice-President, presided in absence of the President.

Mr. George Brodschi, Executive Secretary of the International Center, University of Louisville, introduced the guest speaker, Dr. Robert Hughes Parry, Honorary Physician to His Majesty King George VI, and also Medical Officer of Health for the City of Bristol, whose subject was: "Health Centers in Great Britain." An informal question and answer period followed his address.

The business meeting began at 9:25 p. m.

The minutes of the previous meeting were read and approved.

The report of the Executive Committee was read, recommending that the Jefferson County Medical Society follow the plan of the State Medical Association with regard to members inducted into the Armed Forces, which is that no membership dues will be required of members in service who were in good standing at time of induction. Motion by Dr. David Cox that the report of the Executive Committee be accepted, was seconded and carried.

Dr. Clayton McCarty, Chairman, Committee for the Procurement of Medical Officers, explained the purpose of the card sent each member (to get statistics on medical man power of the state and nation) and urged everyone to fill out the cards and return as soon as possible. He also announced that a local artillery division was in need of a junior and senior medical officer, and as Director Medical Service, Civilian Defense Program, he reported progress made in appointment of the committee and the plan to appoint an alternate for each member of the committee.

The following new members were elected:

Irvin H. Sonne, Sr., M. D., active member and William B. Kirtland, Jr., M. D., and Davis H. Vaughan, M. D., associate members.

The application of Dr. James G. Hutchinson for Emeritus Membership was approved.

The Secretary read a communication from Dr. Pat Imes, Chairman, State Committee on Emergency Medical Service, sent to each County Secretary, requesting the president of the

county society to appoint an emergency medical service committee and make known the personnel of such a committee to the State Committee. This matter was referred to the president for disposition.

The Secretary read a communication from J. P. Sanford, Kentucky State Medical Association, urging members to remit their 1951 dues by April 1.

Dr. J. Murray Kinsman stated the students of U. of L. School of Medicine have voted to become members of the Student A. M. A. The Constitution requires an advisory committee composed of two representatives elected, one by the State Association and one by the County Society. Dr. Overstreet has appointed a representative from the State Association and Dr. Kinsman therefore requested the County Society to appoint a representative. Dr. Minish stated, with the approval of the Society, the President will be asked to appoint a representative of the Society to the Student A. M. A. advisory committee. Adjourned 9:40 p. m.

Austin Bloch, Secretary

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## JEFFERSON

The April meeting of the Jefferson County Medical Society was held on Monday evening, April 16, 1951, at the Seelbach Hotel. Fifty-one members were present for dinner and about 10 additional for the business and scientific sessions.

The meeting was called to order at 7:55 p. m., by the President, Dr. Lytle Atherton.

The minutes of the previous meeting were read by Dr. Bernard Schneider, in the absence of the Secretary, and were approved as read.

Dr. Carlisle Morse read a report of the Public Relations Committee recommending that the Society approve a Public Relations Meeting for doctors' secretaries, sponsored by the Blue Cross-Blue Shield, as outlined by the committee.

There was discussion by Drs. Lawrence T. Minish, Jr., Alfred O. Miller, Alice L. Wakefield, Everett L. Pirkey and David M. Cox. Dr. R. O. Joplin made motion that the report of the Public Relations Committee be accepted and that the committee cooperate with Blue Cross-Blue Shield in working out plans. Seconded and carried.

The Public Relations Committee also recommended that the Society devote five minutes of each meeting to some topic of public relations. Dr. Morse made motion to that effect,

which was seconded by Dr. Joplin, and carried.

The application of Dr. Henry M. Rubel for Emeritus membership was approved.

The President read an announcement of office equipment and furniture for sale by Dr. O. R. Reesor, Brown Bldg., who is retiring.

Dr. Bernard Schneider read the following motion: "It is moved that the subject of library assessments be referred to the Library Committee, the Executive Committee and the Professional Relations Committee for study and recommendations, reporting to this Society not later than the regular meeting of June 18, 1951, as to (1) whether a separate library assessment of each member of this Society should be made, exclusive of the regular dues; (2) what the amount of such assessment, if it is considered appropriate, should be; (3) whether this Society should go on record as opposing an assessment of members of hospital staffs for the support of hospital medical libraries, which procedure now tends to decentralize the efforts of the medical profession in the establishment of a more complete and diversified type of reference library."

There was discussion by Dr. L. T. Minish, and the President suggested that the various committees mentioned by Dr. Schneider get together and discuss this subject, particularly with reference to the assessments for the Jefferson County Medical Library, and report back to the Society as requested by Dr. Schneider.

Scientific Program 8:25 P. M. "Bilateral Cancer of the Breast." By George Benton Sanders. Slides were shown.

Adjourned 9:05 p. m.

Austin Bloch, Secretary.

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### McCRACKEN

The regular meeting of the McCracken County Medical Society was called to order by Dr. W. P. Hall after the dinner at 6:30 P. M. at the Ritz Hotel on Wednesday, April 25, 1951. Twenty-seven members and guests were present.

The scientific program was presented by Dr. Dean Woolsey, St. Louis. His subject was "Ruptured Intervertebral Disc."

The minutes were read and approved for the February meeting. Dr. Logan Weaver gave a report on study of effects of fluorinization of the water supply. Dr. D. Y. Keith made a motion that was seconded by Dr. R. W. Robertson, that the local society go on record as being in favor of this program for Paducah.

The pledge for financial support to the Blue Cross insurance drive was approved by Dr. Orion L. Higdon and Dr. J. V. Pace moved that

this be paid. Seconded by Dr. C. B. Billington and passed.

The motion was made by Dr. E. W. Jackson that Dr. C. P. Mosely, Richland, be given permission to retain his membership in the Lyon County Medical Society. Seconded by Dr. Purdy and passed.

Dr. R. W. Robertson made the motion, seconded by Dr. C. B. Billington and passed that a committee be appointed to serve as Emergency Medical Service Committee. Drs. Logan Weaver, Eugene Blake and C. B. Billington were appointed.

Dr. Orion L. Higdon announced the program for the Southwestern Medical Society Meeting to be held in May.

The motion was made by Dr. C. B. Billington that the usual arrangements be made to entertain the visiting doctors. Seconded by Dr. Theodore Rosenberg and passed.

It was announced that the fourth Wednesday evening in May would be the combined meeting of McCracken Medical Society and the First Councilor District.

The meeting adjourned at 9:45 P. M.

George H. Widener, Secretary

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### SCOTT

Dr. W. S. Allpin entertained the Scott County Medical Society with a dinner meeting at his home on the evening of May 10, 1951. Mrs. Allphin served a delicious fried chicken and old ham dinner. The guests were Dr. Edward H. Ray of Lexington, our guest speaker, Captain T. J. Penn, U. S. Army Medical Corps, Drs. L. F. Heath, H. G. Wells, F. W. Wilt, A. F. Smith, P. H. Crutchfield and H. V. Johnson.

After dinner Dr. Ray read a most interesting and instructive paper on the Symptoms and Treatment of Prostatitis with special emphasis on the transurethral operation.

After a round table discussion and a vote of thanks to Dr. and Mrs. Allphin for their entertainment, the meeting adjourned.

H. V. Johnson, Secretary

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### SCOTT

The regular monthly meeting of the Scott County Medical Society was held at the John Graves Ford Memorial Hospital in Georgetown, on Thursday, June 7, 1951 with the following members present: Drs. W. S. Allphin, L. F. Heath, P. H. Crutchfield, E. C. Barlow, F. W. Wilt and H. V. Johnson.

The reading of the minutes were dispensed



with in order to give our guest speaker more time.

The Secretary introduced Dr. Cathryn R. Handelman, head of the Division of Maternal and Child Health of the Kentucky State Board of Health and Mrs. Helen Curry, Advisory Nurse.

They each made a most interesting talk and asked for a closer cooperation between the Health Unit and the Medical Society in having prenatal care for all expectant mothers and they said our Health Department Nurses stand ready to render any assistance that we see fit.

The Society assured them that we will help at all times and that there has always been cooperation between the two.

Dr. Handelman urged that early immunization be given and records kept and filed with the Health Unit.

H. V. Johnson, Secretary

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#### SHELBY-OLDHAM

Dr. George Perrine entertained the Shelby-Oldham Medical Society with a chicken dinner at the Stone Inn on Thursday, April 26th.

The following members and guests were present: Drs. A. B. Simon, W. H. Nash, L. B. Sternberg, H. B. Mack, Wyatt Norvell, G. E. Houchin, B. F. Shields, A. D. Doak, J. T. Walsh, C. W. Hayes, B. B. Sleadd, M. D. Klein, H. H. Richeson, H. T. Alexander, C. C. Risk and Dr. George Pedigo, Louisville.

After the dinner, Dr. W. H. Nash called the meeting to order, minutes of the last meeting were read and approved. Dr. Walsh gave a report on the conference of the Officers Meeting of County Societies held in Louisville on March 1st.

Dr. Perrine introduced Dr. George Pedigo, Louisville who gave a very interesting talk on "Physiology of ACTH and Cortisone." His talk was well discussed by all present.

C. C. Risk, Secretary

#### SHELBY-OLDHAM

The monthly meeting of the Shelby-Oldham Medical Society was held at the Stone Inn May 24, 1951. Dr. H. H. Richeson was the host.

The following members and guests were present: Drs. W. P. McKee, H. B. Mack, M. D. Klein, H. H. Richeson, A. D. Doak, J. F. Furnish, B. F. Shields, G. E. McMunn, B. B. Sleadd, E. G. Houchin, B. B. Baughman, George Perrine, L. A. Wahle, L. B. Sternberg, W. H. Nash, A. C. Weakley, C. C. Risk and Dr. Foster Coleman, Louisville.

After a delicious dinner the meeting was called to order by the President, Dr. W. H. Nash.

Dr. E. B. Baughman, the councilor of the 7th District, was introduced. He outlined the coming district meeting that will be held in Frankfort on June 28th. Dr. Baughman has visited all counties in the district where much interest was shown in the coming meeting. The program will be presented by members in the district.

The Secretary read a letter from Mrs. Walker Owens in regard to the Ephraim McDowell Memorial at Danville, Ky. The Society voted \$25.00 in furnishing one of the rooms in the McDowell shrine.

Dr. L. A. Wahle was elected chairman of the Diabetes Detection Drive.

The Secretary read a letter from Mr. Paul E. Harris, Supervisor Adult Education, in regard to a course for practical nurses.

At this time Dr. H. H. Richeson, the host, introduced Dr. Foster Coleman, Louisville, who presented a very interesting talk on "Diverticuli of the Gastro Intestinal Tract." His talk was very instructive and was discussed by many present.

Meeting adjourned at 10:00 p.m. The next meeting will be on the 27th of September as there will not be any meetings during the summer months.

C. C. Risk, Secretary

## News Items



**LETITIA KIMSEY, M. D.**  
**Louisville**

Dr. Letitia Kimsey graduated from the University of Louisville School of Medicine with the same 93 classmates she instructed in bacteriology three years ago. She received her master's degree from the University of Louisville in 1943 and in 1946 was promoted from instructor to associate instructor at the University of Louisville School of Medicine. She has taught some 1,700 medical and dental students in the past fifteen years and she enrolled in Medical School in 1946 but continued teaching. We welcome this brilliant woman into our profession.

The Kentucky Obstetrical and Gynecological Society held its fourth annual meeting at the Henry Clay Hotel, Ashland, at which time Dr. Howard Maloney, Covington, was elected president. Dr. Maloney succeeds Dr. Clyde C. Sparks, Ashland. The other officers elected were: Drs. C. J. McDevitt, Murray, Vice-President; J. B. Marshall, Louisville, re-elected Secretary-Treasurer; and Robert Bateman, Somerset, member of the executive committee. Dr. C. C. Sparks, the retiring president, was the moderator for a roundtable discussion that closed the session. The following physicians were on the program: Drs. William Pugh, member of resident staff, General Hospital, Louisville and Conrad G. Collins, professor of gynecology at Tulane University, New Orleans, Louisiana.

Dr. John B. Floyd, manager of the Veterans Administration Hospital, Outwood, resigned his position May 11th. Dr. Floyd was former Medical Director and Superintendent, Waverly Hills Sanatorium, Director of the Division of Tuberculosis, State Department of Health, Chairman of the Commission of the State Tuberculosis Hospitals. He will resume his private practice at Richmond where he had practiced many years before entering Public Health Service.

The following doctors were appointed by Governor Lawrence Wetherby on the advisory committee on Mental Hygiene: Drs. S. S. Ackery, Louisville, Chairman; Dr. Bruce Underwood, State Health Commissioner; John H. Rompf, Lexington and Robert C. Smith, Newport.

Dr. E. M. Ewers, Somerset, announces the association of Dr. Helen L. Hallock in the practice of general medicine. Dr. Hallock was graduated from the University of Louisville School of Medicine in 1947.



**HAROLD F. BERG, M. D.**  
**Louisville**

Dr. Harold F. Berg announces his association with Dr. Alvin B. Ortnier July 1, 1951, Francis Building with practice limited to general and vascular surgery. Dr. Berg was graduated from the University of Louisville School of Medicine in 1942 and served his internship and residency in surgery at the Louisville General Hospital where he has been chief resident for the past year.

Dr. Berg served as a Major in the Medical Corps of the Army during World War II. He is a diplomate of the American Board of Surgery and Consultant to the Medical Division of the Oak Ridge Institute of Nuclear Studies.





JOHN P. BELL, M. D.

Louisville

Dr. John P. Bell, Louisville psychiatrist, was the principal speaker at the annual meeting of the Henderson League of Women Voters on April 7th, 1951. Dr. Bell's subject was "Mental Hygiene in Kentucky."

Dr. Bell was graduated from the University of Kentucky in 1937 with a B. S. degree and was graduated in 1940 from Vanderbilt University School of Medicine. He served his internship at Baltimore City Hospital and received his resident training in psychiatry at New York Hospital, Westchester division, and for a year in Child Psychiatry at the Mental Hygiene Clinic, Louisville.

Dr. Bell, in addition to his private practice, is instructor in psychiatry at the University of Louisville Medical School, a Consultant with the Mental Hygiene Division of the State Department of Health, Consultant to Central State Hospital, Lakeland.

The Michael Reese Hospital Postgraduate School, Chicago, Illinois, is offering a two-week course in "Diseases of the Endocrines—Physiology and Diagnostic Methods." This full-time intensive course will meet from July 9th to July 21st, 1951, and consists of a balanced program of basic information and clinical applications. Dr. Rachmiel Levine, Director, Department of Metabolic and Endocrine Research is coordinator of the course.

Dr. Lee Palmer, Louisville pediatrician, has been named to an advisory committee of the National Doctors Committee for Improved Federal Medical Services. He will represent

the field of pediatrics on the advisory committee of experts from every branch of the medical profession. The National Doctors Committee is an affiliate of the Citizens Committee for the Hoover Report. Dr. Palmer is also chairman of the City-County Board of Health.

J. I. Greenwell, M. D., who has been practicing at New Haven, Kentucky, since 1900, delivered his 4,000th baby on May 20, 1951, at the Flaget Memorial Hospital in Bardstown. A very complimentary article, together with a picture of Dr. Greenwell, mother, and baby was carried on the front page of the Kentucky Standard, printed at Bardstown, in honor of the occasion. Dr. Greenwell, a graduate of the Hospital College of Medicine in 1900, is Councilor for the Fourth District. His practice extends over parts of Nelson, Hardin, Larue, and Marion counties.

Dr. Robert Lich, Jr., head of the Urology Department at the University of Louisville Medical School has been named a member of the Society of Genito-Urinary Surgeons. He is the only Kentucky urologist ever to be admitted to the honorary organization, whose membership is limited to one hundred.

C. E. Reddick, M. D., Louisville, Deputy State Health Commissioner, spoke at the dedication of the State Tuberculosis Hospital in London, June 9, 1951. Former Governor Simeon E. Willis was the principal speaker. This 100 bed hospital was opened January 31, and is now filled to capacity with patients from 17 counties.

Dr. Louis N. Katz, Chicago, spoke before the Kentucky Heart Association at its annual meeting on Wednesday, June 27, of which former Governor Keen Johnson is president. The title of Dr. Katz paper was "Research in Heart Disease." Dr. Katz is the president of the American Heart Association, the director of the cardiovascular department of Michael Reese Hospital's research institute and a lecturer in psychology at the University of Chicago.

About four hundred men and women from many sections of the state voted to incorporate the Kentucky Association for Mental Health at its recent meeting in Louisville. This is a non profit organization and the following temporary directors were elected to serve until October: Barry Bingham, Mrs. John Serpell, Mrs. M. M. Harrison, Louisville, and Mrs. G. Y. Graves, Bowling Green; Mrs. Robert Kinnard,

Danville; Mrs. Chapman Jennings, Paducah; Dr. John H. Rompf, Lexington; Mrs. Frank Yost, Hopkinsville and John Fred Williams, Frankfort.

Dr. Jorge Valles, physician at Waverly Hills Sanitarium, received his American citizenship papers on Friday, June 22. Dr. Valles was born in Barcelona, Spain, in 1907 and received his education in Barcelona. He came to America in 1947.

Dr. George Sprogis is now associated with the Kentucky State Hospital, Danville. Dr. Sprogis is a graduate of the University of Latvia, Riga in 1928. He has had experience with mental patients and also an extensive experience in surgery and internal medicine. He comes to Kentucky State from a rotating internship in Paterson, New Jersey.



**MICHAEL J. HENRY, M. D.**

Louisville

Dr. Michael J. Henry, nationally recognized Louisville surgeon, was honored by St. Joseph Infirmary and leading Catholic dignitaries of the area with a breakfast and dinner at the hospital in observance of his fiftieth anniversary of services.

Dr. Henry has been closely connected with St. Joseph during most of the fifty years since his first job there in 1901 at the age of 11, when he was hired to answer the telephone, deliver messages and do other jobs about the hospital.

Dr. Henry was graduated from the University of Louisville Medical Department in 1921 and served his internship at St. Joseph Infirmary. He later studied for three years at Mayo Clinic, Rochester, Minnesota and in 1916 became associated with the late Dr. Irvin Abell as a general surgeon. In all the years of his practice he has been on the staff at St. Joseph.

Dr. Henry has been chairman of the City-County Health Board and President of the Jefferson County Medical Society and last year he was named to the board of governors of the American College of Surgeons.

## *In Memoriam*



**H. C. T. RICHMOND, M. D.**

Louisville

1885 - 1951

Dr. H. C. T. Richmond, Louisville physician, died May 9th 1951. Dr. Richmond was born in Ewing, Virginia in 1885.

Dr. Richmond began his practice in Louisville shortly after he returned from France after World War I. He was graduated from Lincoln Memorial University, Harrogate, Tennessee and from the University of Louisville Medical Department in 1907. He did postgraduate work in hospitals in New York City.

Dr. Richmond was a member of the American College of Surgeons, the Jefferson County Medical Society and the Kentucky State Medical Association.

**F. S. SMITH, M. D.**

Corbin

1879 - 1951

Dr. F. S. Smith, native of Whitley county, died April 8, 1951 in his winter home in Fort Lauderdale, Florida. Dr. Smith had practiced medicine in Whitley county since 1905. He was graduated from the University of Louisville Medical Department in 1905 and did postgraduate study in surgery in New Orleans and Chicago. Dr. Smith was co-worker of a Corbin hospital which opened in 1922 and later he became sole owner and continued its operation until his recent retirement.



**ELMER N. ESTES, M. D.****Lexington****1883 - 1951**

Dr. Elmer N. Estes, Lexington, died April 14, 1951 after a long illness. A native of Grant county Dr. Estes received his early education in his local county public schools and was graduated from the University of Louisville Medical Department in 1906. After practicing in Cincinnati, Covington and Louisville he located in Lexington in 1915.

Dr. Estes was a member of the Fayette County Medical Society, the Kentucky Medical Association and was a trustee of the Central Kentucky Baptist Hospital and a former staff member of Good Samaritan and St. Joseph's hospitals.

**J. OLIVER KNIGHT, M. D.****Louisville****1886 - 1951**

Dr. J. Oliver Knight, Louisville physician for forty-four years, died Saturday, June 24, 1951. He was born in Hopkinsville in 1884 and was graduated from the University of Louisville Medical Department in 1907. Dr. Knight was a member of the staff of Kentucky Baptist, Deaconess Hospital and Norton Memorial Infirmary and an honorary member of the staff at St. Anthony Hospital.

He was a member of his county, state and National Associations and the Southern Medical Association. He was also medical examiner for Selective Service during both World Wars.

**WILBUR S. HARGROVE, M. D.****Hickory****1866 - 1951**

Dr. Wilbur S. Hargrove, Hickory, died April 2, 1951. A prominent Graves County physician, Dr. Hargrove had practiced medicine in this county for more than sixty years. Dr. Hargrove was graduated from the University of Louisville Medical Department in 1892.

**GORDON S. BUTTORFF, M. D.****Louisville****1899 - 1951**

Dr. Gordon Stephen Buttorff, Louisville, died May 16, 1951 of a cerebral hemorrhage. Dr. Buttorff who had been specializing in Arthritis in recent years had been a practicing physician in Louisville since 1923.

Dr. Buttorff was born in Nashville in 1899. His family moved to Jeffersonville when he was a child and he was graduated from Jeffersonville High School and received a B. S. degree from the Indiana University in 1921. He received his medical degree from the Indiana University School of Medicine in 1923. He did postgraduate work at Washington University, St. Louis, Missouri.

Dr. Buttorff was assistant professor of medicine at the University of Louisville School of Medicine and consultant on Arthritis at Kosair Crippled Children Hospital and the Home for Incurables. He was past president of the St. Anthony Hospital staff and was an active member of the staff at St. Joseph Infirmary, Kentucky Baptist Hospital, St. Anthony, and General Hospital. He was a member of the Jefferson County Medical Society, the Ken-



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RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**



tucky State Medical and the American Medical Associations, the American College of Physicians, American Rheumatism Association, and the Aero Medical Association.



**OSCAR E. BLOCH, SR., M. D.**

**Louisville**

**1871 - 1951**

Dr. Oscar E. Bloch, who died on June 23, 1951, age 79 years, had practiced medicine and surgery in Louisville for 54 years before his retirement in 1947.

He was born in Cromwell, Kentucky, in 1871, and grew up in Woodbury and in Bowling Green, where he attended Ogden College. He graduated in 1893 from the University of Louisville Medical Department. As a medical student he worked in the offices of Drs. Roberts and Yandell. After graduation he taught surgery in the University of Louisville until the early 1900's.

In 1899 he went to Europe, where he studied for a year in clinics of London, Paris, Berlin, Berne, and Vienna.

In 1906 he was a delegate to the International Medical Congress in Lisbon and stayed in Europe three months for further study.

In 1917 he was commissioned Captain in the Army Medical Corps; he was overseas for 9 months.

After 1919 he limited his practice to general surgery. He was a Fellow of the American College of Surgeons, surgeon for the Pennsylvania, C. & O., and New York Central Railroads, and for many years consulting surgeon

for the United States Marine Hospital in Louisville.

His first office in Louisville was on 6th Street, near Kentucky. He then moved to 414 W. Chestnut Street, and, after a short time in an office on 4th Street, between Chestnut and Broadway, moved to the Weissinger-Gaulbert Building, where he remained for 40 years.

His principal extramedical interest was in a great variety of reading. For years he was Chairman of the Library Committee of the Jefferson County Medical Society, and was particularly diligent in obtaining new books for the library.

He was a founder of The Practitioners' Club, now extinct, and was a long-time member of the Louisville Society of Medicine. In 1920, he was President of the Jefferson County Medical Society.

He sent patients to nearly all the hospitals of Louisville, not concentrating especially on any one of them.

He will be missed not only as an intelligent and skillful surgeon, but as a warm, generous, honest, and understanding man, who did good to a great many people.

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**FIDELLA EDWARDS, M. D.**

**Glasgow**

**1874 - 1951**

Dr. Fidella Edwards, Glasgow physician for thirty-one years, died April 5, 1951. Dr. Edwards, a native of Metcalfe county, was graduated from the University of Louisville Medical Department in 1904 and began his practice in Glasgow in 1920.

He was a charter member of Glasgow's Rotary club and served as its president in 1941. He also was district Rotary governor at one time and was for many years a delegate to the Kentucky State Medical Association from his local county society.

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**HENRY THOMAS MORRIS, M. D.**

**Greenup**

**1869 - 1951**

Dr. Henry Thomas Morris, Greenup, died May 23, 1951. A former State senator, Dr. Morris was graduated from the University of Louisville Medical Department in 1897 and had practiced in Greenup county since 1898. Dr. Morris served two terms in the Senate.

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**IN MEMORY OF DR. JAMES C. GRAHAM**

WHEREAS, our friend, brother and beloved co-laborer, Dr. James C. Graham, has been taken from this field of endeavor, due to the frailties of this life, and now having gone before the great Physician, and,

WHEREAS, he has been a good physician to so many in this community, having practiced medicine here for many years, and,

WHEREAS, Dr. Graham was, throughout his life, active in civic, educational and religious affairs of our county and state, having had a vision of, and striven toward, a full, abundant life among us, and having exemplified before his family and his profession such a high standard of deportment and efficiency,

BE IT RESOLVED, that we extend to his bereaved family our deepest sympathy and that a copy of these resolutions be sent to the family, and, a copy each to the Kentucky Medical Association and Green County Record Herald for publication.

This April 10, 1951.

S. J. Simmons, M. D.

J. W. Miller, M. D.

J. M. Dishman, M. D.

Robert L. Shuffett, M. D.

Green County Medical Association.

## BOOK REVIEWS

**HANDBOOK OF NUTRITION: A Symposium**  
Prepared under the auspices of the Council on Foods and Nutrition of the American Medical Association. Second Edition. Published for American Medical Association by The Blakiston Company, Philadelphia. 1951. Price \$4.50.

The leading authorities on Nutrition in America have contributed to the various subjects that bear upon well being of mankind through his food. Ever since the time of Hippocrates the intelligensia of the world have studied some part of this problem. This book is valuable to the physician because it discussed the basic food elements; Fats, Carbohydrates, Protein as well as the trace elements and minerals in the diet. The latter in the past has been discussed only in soil conservation and now the nutritionists recognize that

the soil and its elements have great bearing upon nutrition in man.

This volume discusses all phases of nutrition. Poor diets are often the results of poor food habits rather than the lack of money and the chapters on cheap staple foods are especially interesting during these times of high cost of living.

This book is strongly recommended for the medical profession as well as the laity.

**PRINCIPLES AND PRACTICE OF BACTERIOLOGY:** By Arthur H. Bryan, University of Baltimore Union Memorial Hospital, Baltimore and Charles G. Bryan, Porth and Wympia Hospitals, England. Fourth Edition. Barnes & Noble, Inc. New York Publishers. 1951. Price \$1.75.

This book presents a brief resume of the many aspects of the modern theory and practice of bacteriology. It has a soft cover page and is just the size and price that would suit a doctor's office.

It has many tables, charts, and illustrations which have been combed and condensed from thousands of pages of books, professional and research journals. The viruses and rickettsia have been regrouped according to their selective action and described in the light of electron microscope revelations. The recently discovered human, plant, and animal virus diseases are included. Brief treatises on the newer diagnostic cellular inclusions, and also therapeutic and prophylactic measures, are summarized for each specific infection. The references terminating each chapter have been brought up to date, with the latest editions of standard texts in general, and special work on bacteriology, pathology, public health and medicine.

It is a valuable book for the medical student, the laboratory worker as well as the general practitioner.

At each meeting of the American Medical Association the scientific exhibitors demonstrate new technics and discoveries in the field of bacteriology and its allied sciences. Those of the profession who fail to attend this and other national meetings, may by pursuing this book become familiar with the many new discoveries and also renew their interest in therapeutic and prophylactic measures so well described in this volume.

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## BRACHIAL PLEXUS BLOCK FOR SURGERY OF THE ARM

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Catherine Owen, M. D., Warren Sergeant, M. D.

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LEXINGTON

Recent war surgery revealed the danger of the universal use of general anesthesia and the urgent need of good regional anesthesia. One of the many regional techniques revived was Brachial Plexus Block. Reports of large series of cases have established the fact that this method can be used with complete assurance of obtaining effective, safe, pleasant anesthesia<sup>1,2,3,4</sup>. Brachial Block will produce anesthesia in the bones, joints, and muscles of the arm from the shoulder to the fingers; and in all of the skin of the arm except that which covers the deltoid muscle and that lying over the medial aspect of the arm from the axilla to the elbow. These small segments of skin are readily anesthetized by blocking the Supraclavicular and Intercostohumeral nerves. We have used Brachial Plexus Block in over 300 cases requiring surgery of the arm. They have been most successful for all concerned; patients have been pleased, surgeons have been enthusiastic, and we have been gratified.

Good regional anesthesia involves the use of effective anesthetic solutions, skillful application of proper techniques, and liberal experience. Let us consider first the drugs that are needed for Brachial Blocks.

### Regional Anesthetic Solutions

Many failures of regional anesthesia are due to haphazard preparation and thought-

less selection of anesthetic solutions. The power, and indeed the safety, of hospital stock solutions of procaine varies considerably because of inaccurate measurement, excessive sterilization, deterioration, and contamination<sup>5</sup>. The widespread use of short acting procaine in prolonged procedures is inexcusable because there are several long acting drugs which have been tried and proven<sup>6,7</sup>. Nevertheless, the same dirty yellow flasks of aged in the autoclave procaine keep appearing whenever local anesthesia is done.

The anesthetic drugs which have been recognized in practice and in the laboratory are listed in Table 1. There is much bickering and theorizing about the toxicity and the power of these substances. Practically, the only difference between them is the rapidity with which they act and the duration of their action. We have noted more reactions when using Metycaine, but our experience with this drug was limited by these complications and no conclusions can be drawn. Some complain that it takes Pontocaine and Nupercaine 10 to 15 minutes to act, but this can be readily overcome by combining them with fast acting Procaine. Half strength solutions are used for children, aged, and debilitated persons. It must be noted that duration of local anesthesia depends not only on the anesthetic but on the accuracy with which the drug is injected about the nerves.

It is important to prepare solutions that are nearly isotonic and isoelectric to avoid

Read before Kentucky Society of Anesthesiologists in Louisville, October 19, 1950.

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Table 1  
Common Regional Anesthetic Drugs

	Toxicity	Potency	Anesthetic Index	Duration
Procaine	1	1	1	½ Hr.
Metycaine	1.1	1.1	1	1 Hr.
Intracaine	1.4	1.8	1.3	1 Hr.
Pontocaine	20	20	1	3-4 Hrs.
Nupercaine	16	22	1.4	3-4 Hrs.

From A. R. McIntyre, M. D., in Pitkin's Conduction Anesthesia 8

tissue damage and necrosis. At present it is clinically difficult to achieve perfection in this matter. The ideal may be approached by mixing the solutions in physiological saline or Ringer's solution. A skin wheal with plain distilled water will convince the most doubtful person of the value of using solutions which approximate the composition of tissue fluid.

When Procaine was the only accepted anesthetic its short action was most aggravating and many devices were used to prolong its action. The first of these was the addition of Epinephrine which doubled the duration of Procaine by delaying absorption through its vasospastic effects<sup>8</sup>. It is said that pressor drugs decrease bleeding when used for infiltration anesthesia and increase bleeding when used for nerve blocks. Pressor drugs are often blamed for the reactions that occur with regional anesthesia. They may cause restlessness, tachycardia, and elevation of blood pressure, but it is doubtful that they cause convulsions. Epinephrine strains cardiac activity and it is advisable to substitute less stimulating pressors such as Ephedrine in the presence of cardiac weakness. These minor disadvantages are far outweighed by the benefits of prolonged anesthesia and reduced toxicity and there is little doubt that certain pressor drugs should be used in all regional anesthetic solutions.

Most anesthesiologists agree that 1/200,000 concentrations of Epinephrine will produce optimum satisfaction. 1/400,000 is used for children, aged, and debilitated persons. The folly of measuring Epinephrine by drops is well known and solutions should be prepared by adding ½ cc of 1/1,000 adrenalin to 100 cc of solution to make 1/200,000 strength adrenalin. ¼ cc is added to make 1/400,000 strength. 1/4,000 Ephedrine is used for those with cardiac dysfunction.

For brief procedures we use 2% Procaine with 1/200,000 Adrenalin mixed by

taking 10 cc of 20% Procaine, 90 cc of physiological saline, and ½ cc of 1/1,000 Adrenalin. For longer operations we use 2% Procaine with 0.15% Pontocaine in an isotonic solution of three chlorides and 1/200,000 Adrenalin. This is prepared by using a commercial Pontocaine solution in place of physiological saline which is used for brief procedures. All drugs are mixed shortly before use from ampules or bottles of chemicals made by various drug companies. One-half strength solutions are used for children, aged, and debilitated persons. Discolored solutions are discarded. The small extra time and cost involved in this meticulous sort of preparation is insignificant when compared to the safety and effectiveness of the solutions.

Other substances such as oils, quinine derivatives, organic acids, are of doubtful value in prolonging anesthesia and have been known to cause inflammation and necrosis<sup>9</sup>. Hyaluronidase will hasten the spread of anesthetic solutions through connective tissue but it will not break the barrier of fascia. Since most of the peripheral nerves are enclosed in fascial sheaths, the drug has limited value in regional anesthesia. Eckenhoff and Moore have been disappointed by the action of this chemical when used for Brachial Block<sup>10,11</sup>.

A number of anesthetists are using small ureteral catheters or plastic tubes to carry out continuous nerve blocks<sup>12,13</sup>. Pontocaine and Nupercaine make it unnecessary to use this technique for surgical anesthesia but it is most useful for continuous therapeutic blocks. Continuous nerve block involves only one injection with a large needle through which a fine catheter is threaded and left in place as the needle is withdrawn. Pontocaine solution is injected every four or five hours to produce uninterrupted anesthesia. This idea will undoubtedly increase the effectiveness of therapeutic

blocks which often fail because of intermittent application.

These drugs and techniques make good regional anesthesia. Now, let us consider the techniques which make Brachial Plexus Block successful.

#### Techniques of Brachial Plexus Anesthesia

There are numerous methods of anesthetizing the brachial plexus and these will be enumerated. First, however, it must be emphasized that consideration of the patient is absolutely essential for the success of all regional anesthesia. This involves not only the use of premedication, but careful mental conditioning of the patient, and some thought as to his general comfort while the surgical procedure is being carried out.

Premedication is just as necessary for regional anesthesia as it is for general anesthesia. Healthy adults are given Nembutal 1½ grs. orally and if they are to be hospitalized hypodermic injection of Morphine 1/6 gr. and Scopolamine 1/150 gr. is given. These drugs are given 30 to 60 minutes before the block and if time is short they are all given intravenously 5 minutes before the block. The doses mentioned are varied for use in children, aged, and debilitated persons according to weight and estimated susceptibility. Premedication of this sort affords not only sedation and diminished sensitivity to pain but pharmacologic protection against excessive amounts of local anesthetic solutions<sup>14</sup>.

Premedication offers some sedation but it cannot allay all fears and anxieties unless it is used to excess. So often physicians seem to be concerned with everything but the patient's feelings. All of our patients are told what is to be done, why it is to be done, and how it will feel. They are told that the injection will involve a little pain and that paresthesias may occur. An effort is made to demonstrate the effectiveness of the block before the surgeon is allowed to proceed. During the surgery the anesthetist continues to reassure the patient and to create a cheerful, optimistic mood. Good local anesthesia demands good 'vocal' anesthesia.

The general comfort of the patient is particularly important when surgery is prolonged. The table and the position of the patient on the table must be comfortable. Perfect anesthesia will mean little if the patient develops a severe backache on a poorly padded table. When dis-

comfort develops, small amounts of intravenous barbiturates will produce rapid, pleasant relief.

The Brachial Plexus is readily accessible in the neck and in the axilla. The proximity of the pleura, large blood vessels, other nerves, and the subarachnoid space has stimulated efforts to approach the plexus without disturbing these structures. Five approaches have been described and there are several modifications of each of these <sup>8,15,16,17</sup>.

#### 1. Supraclavicular

Kulenkampff

Knight

Patrick

#### 2. Axillary

Hirschell

Pitkin

Accardo-Adriani

#### 3. Paravertebral

Kappis

#### 4. Lateral

Pitkin

#### 5. Infraclavicular

Bazy

The supraclavicular approach produces uniformly good results with greatest ease and is the most popular. The axillary approach of Accardo and Adriani seems to be equally effective and, in some instances, it is preferable. The other techniques are tedious, somewhat painful, and occasionally ineffective.

The supraclavicular methods block the plexus as it passes over the first rib. Crile used this route in performing the first Brachial Blocks in which the plexus was exposed through an incision in the neck so that the nerves could be bathed in cocaine injected into the endoneurium. Recently Patrick's technique has achieved wide use<sup>16</sup>. The patient is placed supine with the face turned away and the shoulder depressed to bring the first rib near the surface. If the shoulder is drawn up, it is difficult, if not impossible, to locate the first rib. The skin of the neck and surrounding parts is prepared with alcohol. Careful technique is preferred to draping which conceals valuable landmarks. A skin wheal is made one finger above the middle of the clavicle using a ½ inch 27 gauge needle. A 2 inch 22 gauge needle is inserted through this wheal toward the first rib, caudally, dorsally, and medially, (down, back, and in). It is advisable to locate the first rib by starting laterally and working medially so that the rib will



be located before the pleura is pierced. Having found this landmark, the needle is directed to the ventral part of the rib. 2 to 5 cc of anesthetic solution are injected as the needle is withdrawn. The needle is reinjected several times touching the first rib from front to back, "like and old man tapping up the street with his cane"<sup>18</sup>. Each time the needle is withdrawn a quantity of anesthetic solution is injected. This creates a wall of anesthesia between the skin and the first rib that can hardly fail to affect the plexus. If, in inserting the needle, the subclavian vessels are pierced, the needle is simply withdrawn and reinserted in a slightly different position. The needle alone is used for insertion. The syringe is attached only after the first rib is touched. Aspiration is performed while turning the needle through a complete revolution to avoid inadvertent intravenous injection.

Ordinarily, paresthesias are not sought but they do occur in a rather large percentage of cases with this technique. They insure success of the block and permit the use of smaller amounts of anesthetic. Patients are told in advance to expect sudden thrills and to signal by saying 'here!' This instruction is often ignored but almost all patients show discomfort when paresthesias occur. 5 to 10 cc of anesthetic are injected at once when such sensations are produced. In children, aged, and debilitated persons it is wiser to seek paresthesias so that the amount of anesthetic may be limited. In healthy adults we usually use 50 cc of anesthetic, 100 cc have been used in a few husky, young adults, and 175 cc was used in one enormously fat patient. If the anesthetic is limited to such small quantities as 20 cc the anesthetist and the technique will appear inadequate in a large number of cases.

The axillary approach of Accardo and Adriani<sup>17</sup>, is very convenient if it is necessary to block the intercostohumeral nerves along with the plexus. We use this combination in all surgery involving the medial part of the arm from the axilla to the elbow. The patient is placed supine with the arm extended and the hand placed under the head. The axilla is shaved and washed with alcohol. A skin wheal is placed over the axillary artery where the pectoralis major and the latissimus dorsi join the humerus. A 2 inch 22 gauge needle is inserted over the artery to the humerus. 2 to 5 cc of anesthetic

are injected as the needle is withdrawn. The needle is reinserted several times to make a fan shaped pool of anesthetic above the artery. Another fan shaped pool is placed below the artery in the same manner. No effort is made to secure paresthesias but when they occur 5 to 10 cc of anesthetic are injected at once.

The intercostohumeral nerves are blocked by subcutaneous infiltration of the axilla to anesthetize the medial aspect of the arm. The supraclavicular nerves are blocked as they emerge beneath the sternocleidomastoid muscle or as they pass over the shoulder.

The signs of Brachial Plexus Anesthesia are: Tingling and warmth in the arm, relief of pain, flushing and venous distention, pilomotor activity, and in many cases stellate ganglion block. Stellate paralysis produces Horner's syndrome consisting of constricted pupil, ptosis, and enophthalmos. There is also injection of the conjunctiva, (the most obvious sign), stuffiness of the nose, and absence of sweating on the affected side. When the signs of plexus anesthesia occur, the anesthetist may stop the injection and test the motor activity of the arm. If the patient notes weakness the arm is gently lifted and rotated while the site of injection is gently massaged. This indicates the extent of anesthesia and hastens the onset of complete paralysis. Finally, the patient's response to pin prick is determined just as it is in spinal anesthesia. If at any stage in this evaluation it is suspected that anesthesia is inadequate more injections must be made or, if failure seems inevitable, general anesthesia should be induced. Careful, rapid observation permits this evaluation to be done in a surprisingly short time. Surgery is obviously not the method to determine the adequacy of anesthesia. The patient's comfort, safety, and confidence are of first importance.

Effective drugs and proven techniques promote successful Brachial Blocks in a large number of cases. There will be a certain number of failures when the blocks are first attempted, but this will be greatly reduced with experience.

#### Experience With Brachial Blocks

We have used Brachial Blocks almost exclusively for all cases involving surgery of the arm for the last two years. 255 blocks have been done. Of these 48 were performed on children under 15 years of age, while 35 were accomplished in patients over 60. This brief experience and

the larger studies of others indicate the great usefulness of the procedure and the means of handling the few complications which occur.

Closed surgery involving manipulations of fractures and dislocations has been used for injuries in all parts of the arm from the shoulder to the fingers. Surgeons feel that with this anesthesia there is less postoperative swelling and enhanced circulation of blood. Patients almost never require postoperative analgesia because pain relief lingers for 12 to 14 hours in some cases. We were particularly interested to note the excellent anesthesia and relaxation afforded dislocations of the shoulder. This is not frequently mentioned and it has been denied. Pitkin felt that Brachial Block was ideal for this disorder and noted that reduction could be accomplished with little or no effort on the part of the operator. This ease of reduction undoubtedly prevents undue trauma to the shoulder joint.

Open surgery of the arm is readily done with Brachial Block if the limits of the method are understood. Some write that the intercostohumeral nerves extend only to the middle of the arm. This is decidedly not the case as we found to our distress on two occasions when incisions were made about the elbow. Following these unfortunate episodes we have blocked the intercostohumeral nerves in all cases requiring incision of the medial aspect of the arm. If the skin over the deltoid is to be subjected to surgery the supraclavicular nerves must be blocked.

Brachial Block has been used to great advantage in emergency surgery of the arm. Persons wounded in accidents are often in shock or threatened by shock. They are apt to have food in their stomachs which may be aspirated if general anesthesia is used. Beecher has thoroughly outlined the chemical imbalance which exists in patients suffering from recent trauma<sup>19</sup>. This imbalance may be enhanced by the use of general anesthesia. Little is known of the physical condition of most accident victims. Many have anemia, some have metabolic disorders, a few may have circulatory or respiratory failure, septicemia, or neoplastic disease. Such disorders can lead to disaster when the strain of surgery and general anesthesia is added. The action of Brachial Block is limited almost completely to the nerves of the arm and little if any disturbance is created in the rest of

the body. For the same reason, Brachial Block is invaluable for elective surgery in poor risk patients.

General anesthesia for operations performed with fluoroscopy is dangerous because the visual signs of anesthesia, (patient's color, eye reactions, muscle response, and respiration), are impossible to detect. Regional anesthesia is the obvious answer to this problem. It also eliminates the hazards of explosion in the presence of the cautery, bovie, and X-ray.

Patients almost never require postanesthesia care after Brachial Block. They may leave the hospital at once or, if they need postoperative care, return to their wards needing very little attention.

There are, of course, some definite disadvantages to Brachial Block. Infection and neoplasm at the site of injection are not only contraindications but serve to inhibit the action of thoughtlessly injected solutions. Deformity or trauma at the site may prevent injection. Pre-existing nerve dysfunction in the part to be anesthetized is a relative contraindication. There are no reports of permanent paralysis following these procedures but there is no reason to believe that such damage might not develop.

Some failures are bound to occur as they do with all anesthetic techniques. It is human nature to blame the anesthetic, the technique, or the patient. Actually we all know that it is usually the operator who is at fault. In this series of cases general anesthesia had to be used for one out of ten patients at first, but now this is necessary in but one out of fifty patients. General anesthesia was often resorted to before the block was effective but now we wait until good anesthesia develops.

There are certain anatomical pitfalls which will cause failure if they are not appreciated. It must be remembered that the supraclavicular and intercostohumeral nerves are not anesthetized by Brachial Blocks. It is difficult to block the Ulnar nerve with the Supraclavicular approach because the nerve lies immediately behind and beneath the subclavian artery and is missed in avoiding the artery. Then too, the Ulnar nerve may not be completely formed as the plexus passes over the rib. It is well to make deliberate efforts to block this nerve by injecting pools of anesthetic solution over the first rib where the subclavian artery crosses and along the outside of the rib. If this is not suc-



cessful the nerve may be blocked at the ulnar notch of the elbow. According to Accardo and Adriani<sup>17</sup>, the radial nerve may be somewhat inaccessible from the axillary approach because it lies almost beneath the axillary artery. A special effort is made to reach this area either directly by obtaining paresthesias or indirectly by aimed infiltration.

There are some patients in whom the entire plexus is most difficult to reach. The extremely obese person is obviously difficult and it is best to seek paresthesias in such a patient to avoid reactions from excessive amounts of local anesthetic solution. The thin, emaciated patient may be surprisingly difficult. We feel that this is due to the rolling of the nerves in the same way that the veins of such persons roll and also to the close envelopment of the fascial sheath about the plexus. Here, again, paresthesias are diligently sought.

The major complication, and indeed the outstanding disadvantage of regional anesthesia, is the reaction to excessive amounts of anesthetic solutions. Recent experience with intravenous procaine and pontocaine by numerous authors indicates that if patients are carefully watched this complication is not so dangerous. Premedication with barbiturates is essential for all forms of regional anesthesia. This is often forgotten prior to anesthesia but urgently needed when convulsions occur. The amount of anesthetic solution should be limited to 100 cc of 2% procaine in a healthy adult. This amount may be exceeded if injection is carried out slowly but it must be decreased for rapid injection. Limited amounts of dilute solutions must be used for children, aged, and debilitated persons.

When reactions occur there are always premonitory signs even though these may develop but a few second before the reactions. The signs appear thus: drunkenness, thick speech, trembling, optical illusions, increasing muscular tone, cyanosis, and severe convulsions. Reactions can occur with stunning speed as can all the major complications of regional and general anesthesia. It is almost mandatory to have an anesthesia machine ready for instant use as well as a syringe loaded with pentothal. Alert observation will enable prompt treatment. It is amazing how quickly and effectively these reactions can be halted with a few cc of 5% Pentothal.

In our limited experience we have not noted any circulatory depression. This is often mentioned and discussed and we are prepared for it with intravenous pressor drugs such as methedrine or neosynephrine as well as an anesthesia machine to administer oxygen.

Use of the Supraclavicular approaches may result in pneumothorax, and paralysis of the Phrenic<sup>1</sup> or Recurrent Laryngeal<sup>20</sup> nerves. Clinical evidence of such complications is rare but they must not be forgotten. Incipient respiratory or circulatory failure may suddenly burst forth as a result of such impairment. The stellate ganglion is frequently anesthetized with the supraclavicular techniques. Little if any harm will result but patients should be advised of its harmlessness should it occur. There have been a few reports of transient paralysis following brachial blocks. There are no reports of permanent paralysis and there has been no mention of inflammation at the site of injection.

We have been particularly interested in the use of Brachial Blocks for children. Increasing experience has shown that children can enjoy all of the benefits of the refined techniques that have been developed for adults. These methods must be altered to fit the minds and bodies of individual children and this is often difficult. However the extra effort required is more than justified by the results obtained. There is no need to smother and poison children with ether merely because they are small and nervous.

We have used Brachial Blocks in 48 children. For the most part surgery was limited to closed reduction of fractures and dislocations but in 10 cases open surgery was done. These cases have shown that with proper premedication, (determined chiefly by weight), careful mental control, small amounts of dilute anesthetic solutions, and accurate injection these blocks can be used most successfully in children.

The widespread use of general anesthesia for surgery of the arm is lamentable. Brachial Block is as useful for surgery of the upper extremity as spinal anesthesia is for surgery of the abdomen and lower extremity. It can be used for patients of all ages from infancy to old age and it proves most valuable in the presence of almost all varieties of diseases and injuries.

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## PROCTOSIGMOIDOSCOPY IN DIARRHEAS

Wilford L. Cooper, M. D., M. S.

Proctology: Lexington Clinic  
LEXINGTON

Proctosigmoidoscopy is important as a diagnostic aid in persistent diarrheas. With the proctoscope one may demonstrate new growths, ulcerations, fecal impactions, strictures, diverticula, foreign bodies, and inflammatory conditions of the rectum and lower sigmoid. Barger<sup>3</sup> has stated that a proctoscopic examination is the second most important test to determine the cause of diarrhea. The large majority of the organic lesions of the large bowel may be seen in the rectum and lower sigmoid. Some of the lesions which may be observed are: (1) thrombo-ulcerative colitis, (2) amebic, bacillary, and tuberculous colitis, (3) ninety per cent of the organic strictures, (4) seventy per cent of the non-malignant tumors, (5) seventy-five per cent of the malignant tumors originating in the colon, (6) factitial proctitis, (7) lymphogranuloma venereum, (8) foreign bodies, (9) recto-vaginal, recto-vesical and recto-urethral fistulae, (10) invagination of the lower sigmoid into the rectum, and (11) perforation of the rectum or lower sigmoid by foreign objects.

Martin S. Kleckner<sup>13</sup> has stated that with many practitioners, the complaint of a patient suffering with diarrhea conveys little significance from a diagnostic standpoint. This was clearly illustrated

to me recently by a patient who stated that he had had diarrhea for ten weeks and had been to see four different doctors. On questioning the patient it was learned that no stool examinations, no agglutination tests, no cultures of the stool, no proctoscopic examination, and not even a digital examination of the rectum had been performed.

### Correct Diagnosis

A correct diagnosis is essential in order to intelligently treat the patient who complains of diarrhea. A detailed history and a complete physical examination, including a digital examination of the rectum and proctosigmoidoscopy, are necessary. They should be supplemented by a microscopic examination of the stools for parasites, cysts, or ova, and other studies as indicated.

It is not within the scope of this paper to discuss agglutination tests, bacteriologic and culture study of the stools, microscopic examinations of the stools, gastric analysis, cholecystograms, hematological studies, basal metabolism and skin tests in regard to their value in finding the cause of a diarrhea.

### X-Ray In Diagnosis

Many feel that a barium enema is the best aid in finding the cause of a chronic diarrhea, but Swinton and Hare<sup>18</sup> have ex-



plained that it is not possible at the present time with our known radiologic techniques to diagnose many of the lesions of the ampulla of the rectum, the rectosigmoid area, and in certain instances the distal part of the sigmoid. According to Fansler<sup>8</sup>, a negative colon X-ray report lulls the physician and patient into a false security. He feels that an X-ray examination is of little value in rectal lesions. Jones<sup>12</sup> has commented that the average roentgenologist can make a correct diagnosis of carcinoma of the rectum in only 40 per cent of the cases. It is hardly reasonable to depend on such a method when accurate digital and proctoscopic examinations will give the diagnosis in 100 per cent of the cases.

### Colitis

Too often the cause of diarrhea is explained to the patient by using the term "colitis." Especially is this true of the term "mucous colitis" or "spastic colitis." So-called "mucous colitis" is not a disease but a condition of systemic origin. The term "irritable bowel" or "irritable colon" or "unstable colon" should be used to supplant the term "colitis" with its various modifying adjectives. Many names such as "simple colitis," "spastic colitis," "mucous colitis," "catarrhal colitis," "mucomembranous colitis," "myxorrhoea membranacea," "myxoneurosis intestinalis," "fermentative colitis," and "toxic colitis" all indicate colonic manifestations of systemic origin but none adequately directs attention to the basic trouble. They are all suggestive of functional colopathy. Barger<sup>4</sup> feels that no one has ever demonstrated pathologic data sufficient to justify their term as designation of these syndromes. He prefers to use the term "irritable colon." This term at once suggests that the intestinal disorder is only a part of the general disorder and leads one to investigate not only the colonic difficulty but the basic trouble. A derangement of functional behavior not only is present in the large intestine, but in other parts of the gastrointestinal tract as well. Proctoscopic study reveals nothing abnormal and aids in the diagnosis.

### Two Groups

One may briefly divide the diarrheas into two groups, functional and organic. The organic diarrheas are characterized by demonstrable lesions of the intestinal mucosa and the functional diarrheas characterized by the absence of such

lesions. The stools in organic diarrheas may contain pus, blood, mucus, pathogenic bacteria, intestinal parasites and ova. The mucosal changes may be observed through the proctoscope. The mucosa may show a stage of inflammation, erosion, ulceration, necrosis, fibrosis, or stricture. Long continued functional diarrhea may sometimes lead to organic changes and likewise, diarrhea may be absent in the presence of the structural changes of inflammations, ulcers, strictures, and neoplasms.

Gastrogenic, pancreatic, metabolic, dietary, allergic, functional, putrefactive, or fermentative diarrheas, and those associated with sprue, pellagra, and regional enteritis, as well as those due to lead, arsenic, mercury, food poisoning and drugs will be mentioned only to aid in a differential diagnosis. The value of proctosigmoidoscopy will be stressed as an aid to finding the specific cause of persistent diarrheas.

### Other Conditions Present

The more important conditions associated with diarrhea in which the proctoscopic findings aid in a correct diagnosis may be classified as follows:

#### A. Neoplastic

- (1) Carcinoma
- (2) Polyposis or polypoid disease

#### B. Non-Neoplastic

- (1) Bacillary dysentery
- (2) Chronic ulcerative colitis
- (3) Gonorrheal proctitis
- (4) Tuberculous proctitis
- (5) Lymphogranuloma venereum
- (6) Parasitic
  - a) Schistosomal dysentery
  - b) Amebiasis
  - c) Balantidial dysentery
- (7) Foreign bodies
- (8) Fecal impaction
- (9) Diverticulitis
- (10) Factitial proctitis

### NEOPLASTIC

#### Carcinoma

Ault<sup>1</sup> has stated that their statistics show that from 10 to 25 per cent of the patients who have terminal colon lesions of a malignant kind exhibit diarrhea as an early symptom. According to Bacon<sup>2</sup> early morning diarrhea, awakening the patient before his customary time to rise,

is an important early sign of cancer of the rectum.

Briefly, in diarrhea associated with a carcinoma of the rectum, one usually sees on proctosigmoidoscopy a single dusky red cauliflower-like growth which may vary in size and shape. Marked proliferation of tissue is present. The edges of the growth are hard and nodular and the base firm and indurated. If an ulcer is present, it is excavating in character, necrotic and the edges are raised, rolled and nodular. An annular growth may be seen. A biopsy confirms the diagnosis.

### Polyposis

Diarrhea accompanied by griping and cramp-like abdominal pains of the lower abdomen is one of the earliest symptoms presented by patients with disseminated polyposis of the colon. The hereditary or familial type of polyposis has been discussed by Erdmann and Morris<sup>6</sup>, Wesson and Barga<sup>20</sup>, Yeomans<sup>21</sup>, Soper<sup>17</sup>, Mayo and Wakefield<sup>14</sup>, and McKenney<sup>15</sup>, and it usually appears in patients younger than 30-40 years of age. On proctosigmoidoscopy the mucous membrane is diffusely studded with polypoid growths whose form, size, and appearance vary. Lesions with relatively long pedicles may be interspersed between areas of smoother mucosa. As the condition progresses, infection, inflammation, ulceration, and malignant change may alter the picture.

Another type of disseminated polyposis in which diarrhea may occur has been designated by Erdmann and Morris<sup>6</sup> as the "acquired type." Barga and Wesson<sup>20</sup> have called it "post-inflammatory polyposis." Both groups agree that the familial type differs from the acquired type. The acquired type is not a true adenomatous disease but in reality a "pseudo-polyp" formation. This may be seen in long standing cases of ulcerative colitis, amebiasis, bacillary dysentery, etc. The colon in this type of polyposis may present a moth-eaten ulcerated tube, irregularly studded with polyps and exhibiting little, if any, normal mucosa.

Diarrhea is not ordinarily a prominent symptom in single adenomatous polyps of the rectum and lower sigmoid, but the frequent passage of mucus may be experienced. The lesion may vary in size from 3 or 4 mm. to many centimeters in diameter. The lesion may be smooth and shiny, rough and warty, sessile or pedunculated. The sessile lesion is more apt to

be malignant than the pedunculated tumor but the possibility of malignant change should be considered very carefully in all.

A villous tumor, or so-called villous papilloma or papillary adenoma may cause frequent passage of either excessive "rice-water" stools or sticky mucus. Proctoscopic examination reveals a single, soft, velvety, lobulated mass with projecting villi. It is usually of large size. The growth has often been described as resembling a "sea-weed" in appearance.

### NON-NEOPLASTIC

#### Bacillary Dysentery

In acute bacillary dysentery generalized diffuse hyperemia with hemorrhagic edema of the mucosa and bloody oozing may be present. The severe type of acute bacillary dysentery may go beyond the above stage and diffuse superficial ulcerations of the mucosa varying in size from 2 to 3 mm. in diameter, may be found. When the condition becomes chronic, a diffuse inflammatory process will be observed through the sigmoidoscope. There is no point in the wall of the intestine where the mucosa is free from evidence of inflammation. Widespread hyperemia together with spotted, hemorrhagic tissue and edema of the mucous membrane will be seen. Ulcers with margins which are leveled down and adherent to an angry red base may be observed. The margin of the ulcer is not undermined and there is a scattered patchy arrangement of a reddish-gray membrane which may sometimes coalesce and cover large portions of the mucosa. As the process becomes more chronic the ulcers will be shallower, flat, with sharp edges, and disseminated through a membrane which is scarred and contracted irregularly in patches.

#### Chronic Ulcerative Colitis

The term, chronic ulcerative colitis, might be used to include any of the chronic ulcer producing diseases of the rectum and sigmoid such as amebic, tuberculous, bacillary dysentery, etc. In this paper chronic ulcerative colitis will be synonymous with the terms "Ulcerative Colitis" of the Barga type or "Thrombo-ulcerative Colitis" or "Chronic Ulcerative Colitis of the Streptococcal Type" (a term preferred by many). The obscure etiology in this disease leads to the confusion of names. In "Thrombo-ulcerative Colitis"



the mucosa gradually develops from an inflamed appearance to a firm, granular, glistening appearance and minute mucosal abscesses appear. The term, "wet sand," and "sand paper appearance" have been used to describe the picture seen. Ault<sup>1</sup> has stated that it appears as if one had given a sudden "shake of pepper" to an area of the mucosa. The mucosa bleeds easily when touched with a swab. The abscesses are small and rarely larger than 1 mm. in diameter. The disintegration of these abscesses is accompanied by a surface ulceration which may be both discrete and confluent. Numerous small ulcers may coalesce to form large shallow irregular lesions. The intervening mucosa is inflamed and edematous. In the chronic cases or recurrent type, areas of new and old ulcerations are interspersed with areas of healing, scarring and contraction. Irregular, depressed, pock-marked scars may be seen between areas of shaggy, necrotic tissue protuberances and mucosal folds. The lumen becomes contracted. "Geographical ulceration" may be seen, reminding one of a relief map with its geographical irregularities. Stenosis of the bowel develops as an irregular diffuse process with very little tendency to form the "diaphragmatic" type of strictures seen in other conditions. A long irregular tubular narrowing is the rule. In some cases after polypoid degeneration takes place one may have the impression of looking into an inflamed, "moth-eaten" tube irregularly studded with small polyps.

Bargen<sup>4</sup> has emphasized that proctoscopic examination is the most useful and reliable method of making a diagnosis in the thrombo-ulcerative colitis, since the characteristic lesions will be seen in about 95 per cent of the cases.

#### **Gonorrheal Proctitis**

In fulminating cases of gonorrheal proctitis, diarrhea may be a prominent symptom. Although this is rare today, it may be seen in women and is ordinarily secondary to a genital infection and accompanied by tenesmus, sphincter spasm, bearing down pain, pus and blood. On proctosigmoidoscopy there is a marked generalized acute inflammation of the rectal mucosa with hyperemia and hemorrhagic edema. Scattered areas of erosion may occur and purulent cryptitis is common. Stricture, ulceration and fibrosis are not infrequent in the colored race.

Smears for staining may easily be obtained through the proctoscope.

#### **Tuberculous Proctitis**

Tuberculous infection elsewhere in the body is present in the vast majority of instances in the development of tuberculous dysentery. On proctoscopic examination single ulcers to multiple irregular lesions may be encountered. The ulcers may vary in size and shape and are usually transverse to the long axis of the bowel and covered with caseous necrotic purulent material and extend into the submucosa. The ulcers are usually oval or elliptic but may be ragged, irregular and not sharply defined. The dirty grey tenacious slough in the ulcers is very difficult to dislodge. The base may be grey and elevated with yellow tubercles. The intervening mucosa may be clean. Contraction of the lumen of the bowel with formation of sinuses and abscesses may occur. These lesions do not tend to produce as great an inflammatory change accompanied by stenosis, stricture, and granulomatous formation as do some other granulomatous conditions. Scrapings from the ulcers may yield the acid fast bacillus. Smears for staining, material for culture, and a biopsy may be obtained through the proctoscope.

#### **Lymphogranuloma Venereum**

In patients with diarrhea and especially in the colored race one not infrequently encounters lymphogranuloma venereum. This is an infectious disease, usually of venereal origin, caused by an unknown filtrable virus. In this disease, there may develop multiple anorectal fistulae, and cockscomb-like tumefactions around the anal aperture. Proctosigmoidoscopy reveals the familiar tubular stricture with inelasticity of the bowel. Below the stricture there is a granular, friable, edematous, hyperemic mucosa which bleeds easily and contains multiple small ulcers. The mucosa above or proximal to the strictured area presents a grossly normal appearance. A Frei Test is always performed in this type of case. A biopsy and material for a smear may be obtained through the proctoscope.

#### **PARASITIC**

##### **Schistosomiasis**

A condition which was exceedingly rare in the United States before the last war is being recognized more frequently

now in some localities. Schistosomiasis, though very rare, is associated with prolonged bouts of diarrhea which during the quiescent periods may be provoked by dietary indiscretions or the ingestion of alcoholic beverages. On proctosigmoidoscopy one may see distended blood vessels, small nodules, superficial mucosal ulcerations, cicatrices, and polyps. Turell<sup>19</sup> advocates biopsy of the suspicious tissues such as nodules, ulcerations, polyps and anal lesions.

### Amebiasis

Affecting 6 to 10 per cent of the population, amebiasis as a cause of diarrhea is gaining more and more recognition. One should, however, not forget that constipation may be present in amebiasis. On proctosigmoidoscopy, the mucosa of the rectum and lower sigmoid may be normal and this should not rule out amebiasis. A further search for the ameba should be made by stool examinations and smears. Proctosigmoidoscopy may be very revealing, however, in many cases. Ruffin<sup>16</sup> has reported a series of patients in which ulcers were demonstrated by proctoscopic study in 31 out of 35 cases. Smears obtained by proctoscopic examination in this same series were positive in 91 per cent of the cases.

Hinman and Kampmeier<sup>9</sup> reported visible ulcers in 261 cases out of 299 proctoscopic examinations in a study of 400 cases of active amebic dysentery in New Orleans. This high incidence of visible ulcers is not seen in the older cases.

Jackman and Cooper<sup>11</sup> in studying the value of proctoscopy in the diagnosis of amebiasis, found in 115 consecutive cases 20.8 per cent with ulcerations of the lower part of the bowel suggestive of amebiasis. Biopsy and scrapings from the ulcers at the time of proctoscopy afforded the diagnosis in two cases in which repeated examinations of the stools had been negative. The occasional co-existence of a carcinoma or other tumefactive lesion is sufficiently frequent to warrant proctoscopy in every patient with amebiasis.

In amebiasis the findings on proctosigmoidoscopy consist of oval or round ulcers, usually 3 to 5 mm. in diameter, which are punched out or umbilicated. They may be scattered in patches about the mucosa. This superficial ulcer has irregular, sharply defined ragged and undermined edges. It is surrounded by a halo of inflammatory change. The sur-

face of the ulcer is covered with a thick purulent exudate mingled with necrotic material and mucus. Direct examination of the material swabbed or aspirated from these ulcers will ordinarily reveal the ameba.

In older and severe cases of amebiasis, large confluent ulcerations may occur. Here one may see a picture rather similar to the older cases of thrombo-ulcerative colitis with secondarily infected, large, irregular, and "geographical" ulcerations. Stricture formation is unusual unless an inflammatory and proliferative lesion such as an amebic granuloma has developed. Rarely a diffuse type of stenosis of the bowel may occur and here the long "moth eaten" ulcerated tube may be observed.

### Balantidial Dysentery

Balantidiasis is very rare, but with people going to and returning from the Far East, the incidence may increase. Patients go many years with a bloody diarrhea and are unrecognized and mistreated. This largest of the pathogenic protozoa causes ulcerations similar to the larger ulcers in amebiasis and the organism also invades the submucosa. The mucosa between the ulceration appears to be in a relative normal state. This condition is often confused with amebiasis.

It is also necessary to bear in mind the possible presence of other parasitic invaders not mentioned above. Numerous parasitologists do not consider *Giardia Lamblia* a pathogenic parasite, yet descriptions of a *Giardial* dysentery occur many times in recent literature. This is seen more frequently in children who appear to be more susceptible to this flagellate. A proctosigmoidoscopic examination may be of some aid but the diagnosis is the result of finding the parasite in the stools.

Severe diarrhea may sometimes be associated with tapeworms, pinworms, roundworms, whipworms, and trichinella infestation. These are only mentioned because proctosigmoidoscopy is not an important aid in the diagnosis. These conditions are usually diagnosed by finding the parasite or eggs in the stools. It is true, however, that not infrequently one may see pinworms on proctosigmoidoscopy.

Many consider strongyloidiasis and trichomoniasis in their study of diarrheas. Proctosigmoidoscopy in these conditions may be of aid in determining the presence or absence of coexisting conditions and



for the purpose of obtaining stools or smears for study.

### Foreign Bodies

The routes of entry of foreign bodies into the rectum and lower sigmoid may be by ingestion, or formation within the intestinal tract, or penetration from a neighboring viscus, or by introduction through the anus. Time does not permit enumerating the numerous articles and the symptoms produced by each object. Proctosigmoidoscopy is a valuable aid in locating the foreign body which may cause diarrhea.

### Fecal Impaction

More often than realized the history of frequent small liquid stools is explained on the basis of a fecal impaction. This is quickly diagnosed by digital examination of the rectum and proctosigmoidoscopy.

### Diverticulitis

Roentgenographic demonstration of diverticulosis and diverticulitis is well recognized. Proctosigmoidoscopy may be of value both in establishing a diagnosis and in revealing additional pathology in the older group of individuals who have diarrhea associated with diverticulitis. The signs of diverticulitis that may be seen on proctosigmoidoscopy and lead to a diagnosis are: (1) relative immobility of the bowel in a segment which is normally freely movable; (2) angulation of the lumen of the bowel; (3) reduced lumen and mucosal folds; (4) sigmoidal sacculations; (5) seeing the lumen of a diverticulum.

### Factitial Proctitis Or Radiation Proctitis

One of the most stubborn and disturbing diarrheas encountered may be due to radiation proctitis. Evans<sup>7</sup>, in a recent paper, has clarified and contributed materially to a better understanding of this condition.

According to Buie<sup>5</sup>, factitial proctitis is a justifiable lesion which occurs in about 3 per cent of the cases in which radium and roentgen therapy are applied for extrarectal diseases. Buie<sup>5</sup> further states that in 94 per cent of the cases the factitial process is limited to the anterior wall of the rectum and in an additional 5 per cent it involves the anterior wall along with other portions of the rectum. In 91 per cent of his cases it was confined to the lowest 10 cm. of the rectum and in no in-

stance encountered at the Mayo Clinic has it involved the bowel beyond 18 cm. above the pectinate line.

In factitial proctitis a single ulcer is usually seen which is oval or circular and involves all the coats of the anterior rectal wall. The ulcer usually varies from 1 to 3 cm. in diameter with smooth and regular margins. The base is usually covered with a silver-grey or yellowish membrane which is very tough and tenacious. The base may be covered, however, with a dirty greenish-grey slough. The center of the ulcer appears slightly elevated and the edges somewhat depressed forming a prominent gutter with the surrounding mucosa. Telangectasis, which is pathognomonic, is always present in the mucosa surrounding the ulcer. Varying grades of proctitis may extend upward for a distance of 3-6 cm. from the margins of the ulcer. Occasionally more than one ulcer may be encountered. A stricture may form with an organized narrowing of the rectal lumen. The stricture may be partial or complete but is devoid of the nodular excrescences seen in malignancy.

### Summary

The importance of proctosigmoidoscopy in diarrheas has been stressed as a method of diagnosis by direct examination of the rectum and lower sigmoid.

Proctosigmoidoscopy makes available stool examinations, smears and cultures from the mucosal surface, scrapings from ulcers, biopsy, and direct observation of otherwise inaccessible lesions.

Roentgenological investigation, with or without an air contrast study, should be used in harmonious accompaniment with and not take the place of a proctosigmoidoscopic examination.

It is felt that even at the present time, persistent diarrhea is still diagnosed and treated without adequate investigation. Not infrequently a patient who may be suffering with a serious disease is dismissed with an opiate or bismuth and without a proctoscopic examination.

Proctosigmoidoscopy may serve as a valuable aid to follow the therapeutic response in the treatment of a patient with diarrhea.

The presence of more than one disease, such as amebiasis complicating malignancy, or a malignancy complicating chronic ulcerative colitis, etc. should be kept in mind.

The term "colitis" will mean something only if we can demonstrate the cause which is truly producing the condition.

The significance of diarrhea should be recognized and every investigative procedure utilized to determine the etiology as specific therapy may be available.

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## THE GYNECOLOGICAL ASPECT OF BLOOD DYSCRASIAS

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Blood loss during normal menstrual function has no relationship to the blood clotting mechanism. Women given dicumarol or heparin with subsequent reduction of their blood clotting ability to 25% of normal, lose no more blood than before the anticoagulants were given.

A knowledge of this fact has led to the question: Do blood dyscrasias cause uterine bleeding? Is the bleeding occasionally encountered in a woman with a blood disease the result of her hemorrhagic disease or some gynecologic lesion?

Israel and Mendel<sup>1</sup> report that organic uterine pathology cannot be demonstrated in many patients with blood diseases. Curettage was done on one of two fatal cases of thrombocytopenic purpura reported by Walsh and Donlon<sup>2</sup> and no uterine cause for bleeding was found.

### Gynecologic Etiology

Barnes<sup>3</sup> though, reported that a gynecologic cause for uterine bleeding can be demonstrated in each case of blood dyscrasia. During one and a half years the female patients, ages thirteen through

thirty, seen by Doan for blood diseases were subjected to curettage by Barnes. They reported such lesions as endometrial hyperplasia, leiomyoma, and uterine polyps present, and concluded that these conditions cause the hypermenorrhea. They also noticed that hypermenorrhea was twice as common in patients with blood dyscrasias as in a control group. This finding would make one wonder if all uterine bleeding in patients with blood dyscrasias was caused by a definite gynecologic lesion.

### Abnormal Uterine Bleeding

Although abnormal uterine bleeding is not a common condition in women with blood disease, it is seen probably most often in patients with thrombocytopenic purpura. Since this disease has some tendency to occur in young females, it is not surprising to encounter some with uterine hemorrhage as their only bleeding point. L. Snaith<sup>4</sup> reported one case and discussed two others of thrombocytopenic purpura in which menorrhagia was the only significant symptom. I will cite a similar case.

Agranulocytosis, acute leukemia and



aplastic anemia may show genital tract involvement in the form of ulceration of the mucous membrane of the vulva and vagina. These ulcers are similar to those seen on other mucous membranes in these diseases.

### Case Report

**Case Report:** This fourteen year old girl had a long history of "bleeding easily," many episodes of epistaxis, and "bruises easily." Her first menstrual period began on May 14, 1949. The bleeding became very profuse and she passed several large clots. The bleeding continued and her blood loss was so great that she was admitted to the hospital on May 21, 1949.

She gave a history of swollen joints after exercise. She had no tarry stools, hematemesis or history of familial bleeding.

Examination on admission revealed a "bled-out" girl with several purpuric spots over the skin of the trunk of her body. Her blood pressure was 76/40. There was no lymphadenopathy, the liver and spleen were not palpable. The remainder of her physical was negative. The hymen was intact. Rectal examination revealed a small anterior uterus.

She was transfused immediately with 500 cc. of whole blood and her blood pressure was then 120/60.

Vitamin K, Vitamin C and Rutin were administered along with repeated transfusions until her blood count was up to a normal level. Her general condition improved but the vaginal bleeding continued and she was using up to seven pads daily.

On the ninth hospital day she was started on progesterone, 10 mgms. daily, administered intramuscularly. Three days later the vaginal bleeding stopped.

Her platelet count was now down to 21,700 (It was 65,280 on admission). Bone marrow was essentially normal and splenectomy was recommended. It was carried out on June 6, 1949. The patient

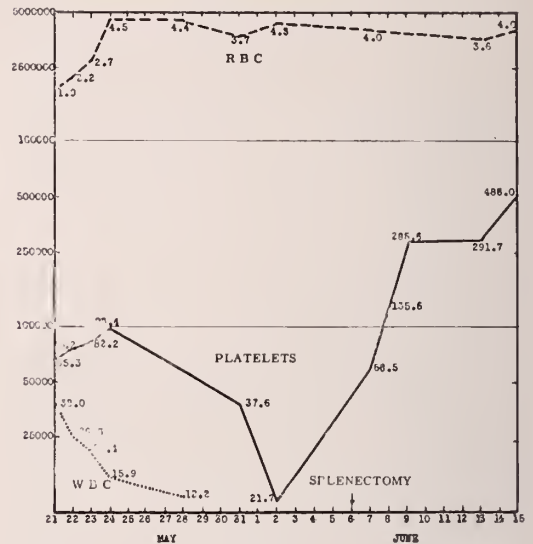


Figure I

withstood the surgery well and improved rapidly following the operation. She had a total of eight transfusions.

### Laboratory Review

A review of her laboratory work gives a good picture of her progress.

5-21-49 RBC 1.9, Hgb. 4.95 Gm., WBC 38,000, Neutrophils 94.5%, Lymphocytes 5%, Monocytes 0.5%, platelets 65,280. Bleeding time 25" Clotting time 4' 18".

5-22-49 RBC 2.2, Hgb. 6.15, platelets 75,240, WBC 26,500, prothrombin, 59%.

5-23-49 RBC 2.7, Hgb. 7.65, WBC 21,400, platelets 82,200.

5-24-49 RBC 4.5, Hgb. 12.45, WBC 15,900, platelets 96,400.

5-28-49 RBC 4.4, Hgb. 12.3, WBC 12,200.

5-31-49 RBC 3.76, Hgb. 10.95, platelets 37,600.

6-2-49 RBC 4.34, Hgb. 12.6, platelets 21,700.

Operation on 6-6-49.

6-7-49 RBC 4.04, Hgb. 11.25, platelets 58,580.

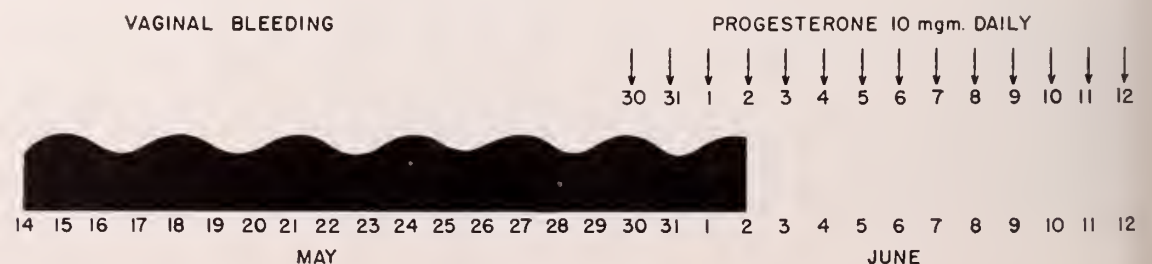


Figure II

6- 8-49 Platelets 135,660.  
6- 9-49 Platelets 285,600.  
6-13-49 RBC 3.68, Hgb. 11.1, platelets 291,760.  
6-15-49 RBC 4.0, Hgb. 12.75, platelets 488,000.

The patient was discharged in good condition on June 17, 1949.

From this case and the ones cited in the literature, it becomes apparent that uterine bleeding is associated with blood dyscrasias, and investigation of a prob-

lem of menorrhagia, especially in young women, should include blood studies. The mucous membranes of the genital tract exclusive of the endometrium, can be the site of hemorrhage, although in most instances the bleeding is from the endometrium.

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THE EARLY DIAGNOSIS OF POLIOMYELITIS

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LOUISVILLE

A plunge into the question of early diagnosis in poliomyelitis might well be prefaced with a few brief background statements. We formerly thought of poliomyelitis as a disease occurring in troublesome irregular epidemics, primarily appearing in the Northern and Northeastern parts of our country, and of chief importance to towns and cities. The experience of the past 2 to 3 years should disabuse our minds of such a relatively simple pattern. The 42,174 reported cases of 1949 originated throughout the entire country, and came upon the heels of a large total of 27,680 cases in the preceding year of 1948. Last year, the third in succession, the reported total was again high, with 33,344 cases. We have shared in this unhappy experience in Kentucky. Thus in 1949 there were 687 cases, coming from 101 of our 120 counties. Last year again, there were 682 cases from 91 of our 120 counties.

Incidence in United States

Actually if we break down the incidence of poliomyelitis in the United States during the past 12 years into 3 successive 4-year periods we find that in the first period, i. e., 1939-1942 inclusive, there were 30,271 cases, with 70,288 cases in the next four-year period, and a rise to 113,932 cases for the four year period just

ended. (Fig. 1) This step-like increase has also reflected, unfortunately, our experience in Kentucky. Clearly the clinical disease is very much with us and in all parts of the country. It has currently become virtually an endemic disease which commands the attention of all of us.

Natural History of the Disease

One could oversimplify the natural history of poliomyelitis by saying that it is a virus infection only of human beings, without any established extra-human reservoir of infection, producing a wide clinical spectrum ranging from no detectable illness to a rapidly paralytic death, an infection whose portal of entry and of exit and whose means of spread are but incompletely understood, and that when the recognizable form of the

POLIOMYELITIS - U.S.A.

CASES REPORTED 1939-1950 INCLUSIVE  
( BY 4 YEAR PERIODS )

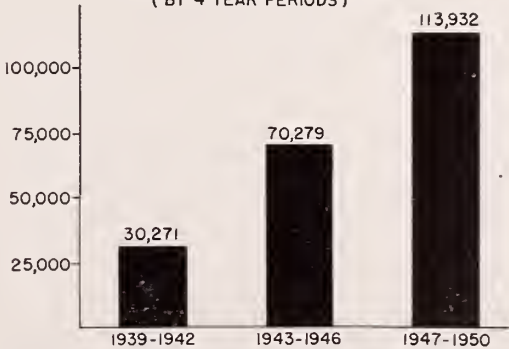


Figure I

Read before the First Councilor District Meeting of the Kentucky State Medical Association, Fulton, January 17, 1951.  
From Department of Pediatrics, University of Louisville School of Medicine and the Kentucky Child Health Foundation.



disease appears in a community, there are probably vast numbers of silent infections. Actually this brief summary by no means represents the entirety of knowledge of the natural history of poliomyelitis but serves rather to indicate how much remains to be uncovered. Despite what has been learned of this disease we have yet to answer: why have recognizable epidemics emerged only in relatively modern times? Why have countries with the highest material standards of living had the worst paralytic affliction? Why are the overt manifestations of the disease seasonal and erratic? How can we explain the fact that of the vast numbers of individuals infected, relatively few display the paralytic consequences which represent our chief concern as doctors?

### Virology and Types

This is not the place to go into the virology of poliomyelitis extensively. I would only say that it was formerly believed that poliomyelitis virus was anti-genically a single and homogeneous entity. Recent research has shown that, as with influenza virus, there are multiple antigenic types of poliomyelitis virus. (1). So far, three distinct types are known, all presumably capable of producing the wide spectral range of human illness from almost no symptoms to paralytic death. There may be more than three basic types of the poliomyelitis virus. At the present time a large scale coordinated typing program has been set up by the National Foundation for Infantile Paralysis in several university medical centers to answer this and related fundamental questions on the etiology and immunology of the disease.

### Coxsackie Virus

In connection with poliomyelitis virus there should be mentioned a group of viruses isolated barely two years ago from some patients in New York State. (2). The public press has referred to this as "pseudo polio virus"; its accepted name in the laboratory is Coxsackie virus, derived from the name of the town in which the initial patients resided. This group of viruses has been repeatedly isolated from throat swabs and stools of patients who have had an influenza-like illness, at times with spinal and nuchal rigidity and in at least a few instances some transitory muscular weakness. It may be recovered alone or together with true poliomyelitis virus, and

specific antibodies appear in the patients' serum in convalescence. To the best of my knowledge, it has not been recovered from human nervous tissue nor have fatalities been ascribed to its effects in the absence of concomitant poliomyelitis virus. This group of viruses can be propagated in suckling mice and hamsters in whom the usual lesion produced consists of a muscular degeneration. It is biologically *unrelated* to the groups of poliomyelitis viruses referred to. What its actual importance is as a public health problem remains to be determined. It is possible that some epidemics of poliomyelitis in which the paralytic rate and the death rate were very low can be ascribed in part to this virus.

### Value of Early Diagnosis

When there was no suitable therapy for tuberculous meningitis, the incentive for *early* diagnosis was considerably less than is now the case. Although we have yet to develop specific agents in the therapy of poliomyelitis we have in recent years made certain observations which impose upon us a high obligation for the early detection of the disease. Thus, we have come to understand that during the incubatory and prodromal stage of this widespread infection, there exists a fine balance between the host and the virus. We are not clear about all of the host factors which determine the outcome, but we have clinical cause to believe that continued physical activity and fatigue at this stage have a pronounced effect upon the development and the localization of paralysis. (3). Recent experimental data on the influence of the adrenal product Cortisone in precipitating manifest poliomyelitis infection has a bearing on "stress" in this connection. (4). Our chief clinical problems are with the paralytic consequences, and prompt bed rest at home during the early stage of this host-virus struggle may help reduce the more serious forms of infection with the poliomyelitis virus.

If we agree then that early diagnosis has more than academic importance, let us see how our index of suspicion and criteria for *presumptive* early diagnosis can be sharpened.

### Presumptive Early Diagnosis

At the outset, it must be stated that there is no simple confirmatory laboratory test whatever for infection with poliomyelitis virus. Similarly there is no

pathognomonic sign clinically, except of course paralysis itself, which is not of interest to us for the *early presumptive* diagnosis.

### Silent Infection

It has been established fairly well now that when poliomyelitis virus becomes disseminated in a community, for every patient there are many individuals with silent infections. These are either asymptomatic temporary carriers, or else have so mild and brief an illness as to defy any detection. If we narrow our sights upon that relatively small group with any detectable illness, we find even here a whole spectral range of illnesses, which we have come to classify into three kinds: (5).

(1) Paralytic, including spinal, bulbar and encephalitic

(2) Nonparalytic, and

(3) The abortive cases, which probably predominate.

These three types of illness in any given patient may remain distinct or one may blend into the next more severe form. I shall emphasize the *early* diagnosis of the *abortive* form in view of the importance of putting such patients at rest in bed.

### Symptoms of Abortive Type

Abortive poliomyelitis is a *presumptive clinical diagnosis* which can be made with any degree of confidence only during a poliomyelitis outbreak. We usually do not think of it until at least one case of frank paralytic poliomyelitis has appeared in a given community. Then, a child or adult with headache, sore throat, lassitude, disinterest in play or disinterest in food, a feeling of *la grippe* and a change in bowel habit, (particularly constipation) arouses suspicion. If to this indefinite systemic picture is added fever of 100° to 103°, it becomes likely that the host-poliomyelitis virus fight is on. Such patients may truly have a relatively mild illness, or may, with only the symptoms just mentioned, be feeling ill enough to remain in bed without being urged to. At this stage the headache, if present, is commonly generalized. Sore throat is a fairly common subjective complaint in such patients and yet it is surprising how little one may see upon pharyngeal inspection. In younger children the tonsils may be a bit prominent, but seldom with much exudate or accompanying adenopathy. Older children and adults literally show almost no detectable change to account for their

sore throat. It should be added that a running nose is seldom a feature of this disease. It is the throat and not the nose which suffers, and perhaps the explanation is that the throat is the likely portal of entry of virus. (6). In any event, during a poliomyelitis outbreak the subjective complaint of sore throat is suspicious. The child almost always has fever at this stage, the adult somewhat less so. Anorexia is common as is constipation rather than diarrhea. The vast majority of such patients will stoutly deny contact with poliomyelitis. This, of course, is not surprising in view of the great numbers of scot-free temporary carriers who may have been their source of infection.

### Later Symptoms and Treatment

At this stage, there may be some vague general muscle aches and pains as in *la grippe* in distinction to the more clear-cut midline neck, back and hamstring muscle pain of the clear-cut nonparalytic and paralytic forms of poliomyelitis. As mentioned before some of these patients are feeling badly enough to be quite willing to stay in bed: but it is important indeed for *all* such patients to be kept in bed at home, at least until fever-free and symptom-free for forty-eight hours. The art of the physician is often taxed to keep such patients at rest, but it is important. Despite bed rest some will go on to the nonparalytic and paralytic forms, but the majority will be spared. The laboratory is of little or no help in differential diagnosis under these circumstances. Although in common use nowadays for patients with these symptoms, no benefit whatever is observed from the use of antibiotics under these circumstances. Indeed, the promiscuous use of therapeutic agents *by injection* at this stage may even be deleterious. (7).

Such patients with presumptive abortive poliomyelitis should not be reported to the authorities as poliomyelitis unless they chance to progress through the spectral range into definite nonparalytic or paralytic stages. Similarly, for patients with only the systemic abortive form of poliomyelitis infection, it is rarely, if ever, justified to make a statement even suggesting this disease to the parents or patients. While it is impossible to measure and equate the suffering caused annually by the panic and anxiety to the suffering caused by the clinical ravages of the disease itself, one big area of our duty as physicians is in the sphere of re-



ducing the dread of the disease.

### Quick Recovery Type

The vast majority of patients described above recover rather quickly. Despite bed rest a number of patients, particularly adults who tend to have less fever in this systemic stage, will proceed to signs of meningeal irritation. Others, particularly children, *will have a symptom-free interlude*, sometimes for as long as a week, so that when symptoms reappear it may be thought to represent an entirely new illness. Headache recurs now, as does temperature and listlessness. Anorexia may be succeeded by actual vomiting. Constipation and mild difficulty in voiding may be bothersome even before definite nuchal or spinal rigidity can be elicited. Soon muscular pains appear, chiefly in the mid-axis of the neck and spine and into the tendon areas of the hamstring muscles. These subjective complaints call for a good clinical examination during which it is *really essential for the child or adult to be unclothed and recumbent*. Delay in recognizing spinal rigidity and hamstring spasm will occur repeatedly unless these areas are looked at as well as palpated. These signs herald the onset of the nonparalytic and/or the paralytic forms.

### Active and Passive Tests

Except for infants, the *active* tests carried out by the patient himself should be done first. He should be asked to sit up unassisted, and be closely observed. If this action causes undue effort, if the brow wrinkles from pain, if the knees flex upward sharply, if the child turns a bit to the side in sitting up, and then places his hands on the table or bed behind him in the tripod position, there is unmistakable nuchal and spinal rigidity. Then, while in the sitting position, ask the patient to flex the chin toward the chest and observe whether this is done freely. Finally of the useful active tests, with the child recumbent press the knees down gently and ask him to sit up and *kiss the knees*. (Fig. 2). If the knees are drawn up sharply in order to accomplish this, or if the maneuver cannot be completed at all, there is evidence of nuchal-spinal rigidity. If still undecided, one proceeds to the *passive* tests carried out by the examiner. Kernig and Brudzinski signs are sought. Gentle flexion of the occiput and neck forward will elicit nuchal rigidity which may precede spinal



Figure II

rigidity in some patients. *Head drop* is a suggestive early sign, and is elicited by placing one's hands under the shoulders and lifting forward. Normally the head comes along in the same plane. Gently running the finger tips over the erector spinae group, the glutei, the hamstrings and the calves should then be done in order to learn whether tightness or tenderness are present.

In these early stages the reflexes are normal and active, and unless paralysis is to supervene, remain so. Generally, changes in reflexes (which may at first be *either* hyperactive or depressed) *precede* the advent of weakness by twelve to twenty-four hours and it is, therefore, important to detect such changes, particularly in nonparalytic patients being managed at home. Usually the superficial reflexes are the first to be diminished, i. e., the cremasteric, the upper and lower abdominal reflexes, and the reflexes of the spinal and gluteal muscles. These spinal and gluteal reflexes deserve to be tested more often than is done, and are readily tested by lightly tapping segmentally downward on each side of the spine. At times they disappear even *before* the abdominals, and may herald impending weakness or paralysis at an early stage. Changes in the *deep* tendon reflexes whether exaggerated or depressed may, a bit later on, herald impending weakness.

Finally, after examining the tongue, throat and palatal muscles it is well to ask children particularly to say "cookie," "candy" or a similar hard-consonant word. Occasionally bulbar poliomyelitis is heralded by nasal voice before there is any swallowing difficulty. If hard consonant words are repeated clearly and normally it serves not only to reassure, but as a base-line if tested subsequently.

If there is early evidence of nuchal or spinal rigidity but no facial weakness or alteration reflexes, the questions of lumbar puncture and of whether to hospitalize arise. Judgment based upon prevailing circumstances should determine the course. If home conditions are suitable, and if the physician can see the patient often enough to make a rapid check for paralysis, then there is no gain from hospitalization. There is slowly growing this desirable tendency to keep nonparalytic and mildly paralytic patients at home, although it can never achieve universal adoption, particularly in rural areas. There is nothing pathognomonic of poliomyelitis in the results of a lumbar puncture, and it is my belief that this procedure is often performed promiscuously during poliomyelitis outbreaks. (8).

### Summary

Exposure to poliomyelitis virus may result in (a) completely silent infection (b) abortive poliomyelitis—with no signs of meningeal or other C. N. S. change and which may masquerade as la grippe or influenza clinically (c) nonparalytic poliomyelitis—with nuchal-spinal rigidity but no weakness and (d) paralytic poliomyelitis of varying severity.

One clinical form may blend into the next more severe stage. Fatigue, trauma, inoculations and related stress may pre-

cipitate silent infection into overt disease. The early presumptive diagnosis of abortive poliomyelitis accompanied by bodily rest is important.

The diagnosis of poliomyelitis is clinical. There are no readily available confirmatory tests.

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## PREGNANCY WITH CONGENITAL ANOMALIES OF THE GENITAL TRACT

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The vagina and uterus are formed in the embryo by the fusion of the two müllerian ducts. The fusion takes place from below upward. Lack of fusion at any or all points throughout the canals can explain almost all the anomalies observed.

### Descriptions of Various Types of Anomalies

Descriptions of the various types of anomalies are as follows:

1. UTERUS SUBSEPTUS UNICOLLIS  
Vagina and uterus normal except for a fundic septum occupying about 1/3 to 1/2 of the uterine cavity.

2. UTERUS SEPTUS DUPLEX, DOUBLE VAGINA

The external configuration of the uterus is normal in the fundus, broad in the lower segment. There are two uterine cavities, two cervices, and double vaginas.

3. UTERUS ARCUATUS  
Normal except for a depression in the fundus.
4. UTERUS BICORNIS UNICOLLIS  
A more marked degree of fundic depression with a partial fundic septum.
5. UTERUS BICORNIS SUBSEPTUS  
A marked fundic depression with a definite septum extending from the



fundic groove to the level of the internal os.

6. **UTERUS BICORNIS SEPTUS**  
Single cervix. Double fundus with a septum extending from the fundic depression to within the cervical canal.
7. **UTERUS BIFORIS SUPRA SIMPLEX**  
Normal except double cervix with septum extending from external to internal os.
8. **PARTIAL GYNATRESIA**  
Vagina and uterus present, but with no connecting cervix with its canal.
9. **UTERUS BICORNIS DUPLEX, DOUBLE VAGINA**  
Duplication of uterus, cervix and vagina with the two uteri joined together except in the upper fundus.
10. **UTERUS DIDELPHYS, DOUBLE VAGINA**  
Two uteri, joined at the level of the cervix, two cervices, double vagina.
11. **UTERUS SEPTUS DUPLEX**  
Single vagina, double cervix, septum from external os of joined cervices to the fundus with no fundal depression.
12. **UTERUS BICORNIS UNICOLLIS, ONE RUDIMENTARY HORN**  
Complete development of one mullerian duct to form vagina, cervix, and uterus. Development of opposite duct to form only part of a separate uterine body.
13. **UTERUS DIDELPHYS, TWO RUDIMENTARY HORNS, GYNATRESIA**  
Vagina present, no cervix, two rudimentary horns of uterus.
14. **UTERUS UNICORNIS**  
Apparently complete absence of the mullerian elements on one side, but good development on the other.

### Pregnancy Complications

The presence of any of the anomalies just described in which there is no gynaecosis allows pregnancy to ensue. Pregnancy superimposed on any of these anomalies will almost always result in some subsequent abnormality during the gestational period.

When pregnancy occurs in one horn of a double uterus it is ordinarily undisturbed. The non-pregnant side grows somewhat and forms a decidua similar to ectopic gestation, which it really is as far as the non-occupied side is concerned. The non-pregnant side may cast out its decidua while the pregnancy continues on

the pregnant side. Unless the physician is aware of the duplicated parts, he may make a diagnosis of incomplete abortion, and proceed to curette a live ovum. The abortion rate in these patients is reported to be from 45 to 55%. Curettage may be difficult because of partial or incomplete septa, or because of lateral angulation of the abnormal uterine body.

### Labor Complications

Labor is often normal, but many complications are encountered and have been reported. Weak uterine contractions, atony of the uterus with post-partum hemorrhage in the third stage and adherent placenta are some of these. With double uterus, the non-pregnant portion may prolapse and act as an obstructing tumor. The non-pregnant cervix may be forced downward by the descending head. The uterus may rupture because of poor musculature and a vaginal septum may act as an obstruction.

Septate uteri may have the following complications: Breech and transverse presentations, weak labor pains, post-partum atony, rigidity of the cervix, and adherent placenta on the septum, and if the septum is in the cervix, obstruction to labor. The fetus in breech presentation may straddle such a septum.

In the journal of Obstetrics & Gynecology of the British Empire for August 1945, Stanley Way reports on 33 pregnancies occurring in 12 patients with genital tract anomalies. The following complications occurred: Transverse presentation 12, abortion 12, breech presentation 4, premature labor 3, retention of whole or part of placenta 3, prolapse of umbilical cord 2, placenta praevia 2. Of the 22 viable babies delivered, 4 were stillborn, 1 died after breech delivery, and 2 died of causes unrelated to the genital tract deformity.

### Case Reports

The literature is sparse on this subject. I have admittedly made use of several standard textbooks of obstetrics plus the article just quoted in order to provide the background for the following report of 7 cases of congenital anomaly of the genital tract with pregnancy, with which I have been associated in the past three years either as the obstetrician or the consulting obstetrician. These cases have been of considerable interest to me in that they present unusual problems under unusual conditions.

CASE 1. Mrs. C. B. was a para 0, gravida I, 28 years old. History revealed episodes of functional bleeding necessitating D & C with discovery of uterine septum. Examination revealed a 6 weeks gestation in one side of the asymmetrically enlarged uterus. Incomplete spontaneous abortion occurred at 3 months gestation. D & C again demonstrated the uterine septum. A year later she again became pregnant. This resulted in a missed abortion at 8 weeks. The gestation products degenerated and passed piece-meal over a period of 4 weeks. Normal menses resumed about one month later.

CASE 2. Mrs. C. D. was a para I, gravida II, first seen in labor at 36 weeks. First stage—12 hours. Second stage—40 minutes. Delivered under saddle block anesthesia by low forceps and episiotomy from L. O. A. of a 5 pound 8 ounce living child. Third stage—38 minutes. No sign of separation of the placenta. A definite uterine fundus depression was felt and the left side of the uterus was larger than the right side. The tightly attached placenta was removed manually from the left horn of a bicornate uterus. Postpartum course uneventful. At 6 weeks the uterine fundus was broader than normal.

CASE 3. Mrs. O. P. was a para I, gravida III. Her first delivery was of a persistent occipito-sacral by low forceps and episiotomy after 24 hours of labor at 36 weeks gestation. Her second pregnancy resulted in spontaneous abortion at about 3 months. With the third pregnancy a deep depression was noted in the uterine fundus early in the 7th month. At 37 weeks, after a first stage of 4½ hours and a second stage of 17 minutes she was delivered of a living 7 pound 7 ounce baby from occipito-sacral position by low forceps rotation and extraction after episiotomy. The third stage resulted in manual removal of the placenta from the right side of a bicornate uterus with a partial fundic septum after a wait of one hour and 12 minutes. Post-partum course was uneventful.

CASE 4. Mrs. P. H. W. was a para 0, gravida II whose first pregnancy resulted in a spontaneous abortion at 2½-3 months. Following the abortion a vaginal septum had been removed at which time her physician discovered a double cervix and complete uterine septum. With the present pregnancy, the patient had a first stage of about 8 hours. At complete dilatation she was delivered after episiotomy by breech extraction, the position being a

double footling R. S. T. Third stage 6 minutes. Uneventful post-partum course. Living infant.

CASE 5. Mrs. B. T. was a 17-year-old, para 0, gravida I, at 35 weeks gestation. She was found to have a vaginal septum and a double cervix. Labor began at 42 weeks. The first stage lasted 22 hours, during which time the left cervix dilated so that the septum between it and the right cervix was destroyed. The vaginal septum was removed after complete dilatation of the cervix and a live infant was delivered from L. O. P. by low forceps rotation and extraction after episiotomy. Six weeks post-partum examination revealed one apparently normal cervix and vagina with slight ridges anterior and posterior where the vaginal septum had been.

CASE 6. Mrs. R. D. was first seen in June of 1948. She was a 21-year-old, para I, gravida II. Her previous pregnancy had called her physician's attention to a double cervix and vaginal septum. During labor at 36 weeks her obstetrician discovered an obstructing mass below the partially dilated right cervix. The cervix attained only 3½ fingers dilatation at which time progress stopped. A classical caesarian section was performed on the right uterus of a uterus didelphys. The left uterus was the size of a 2½ month gestation. Post-operatively the patient developed atelectasis, bronchopneumonia, and a wound infection. Some months later a general surgeon removed the vaginal septum and told Mrs. D. that subsequent deliveries would be normal.

During the second pregnancy, it was felt that the fetus was in the left, unscarred uterus. At 35 weeks gestation, after a 12 hour first stage a 4 pound 2 ounce living fetus was delivered from the left uterus from L. S. T. frank breech presentation. No sign of placental separation occurred after 45 minutes. A manual removal of the placenta was very difficult because of the sharp, lateral angulation of the uterus. Uneventful post-partum course.

The third pregnancy went to full term since it was thought to be again in the unscarred left uterus. Such was not the case, so instead of doing an elective section with a correct diagnosis of right uterine pregnancy, we were confronted with a rupture of the right uterus and a dead fetus lying free in the abdomen and the mother in shock. An immediate laparotomy was done. The fetus and pla-



centa were removed from the peritoneal cavity and a right supra-cervical hysterectomy was done. The patient's condition improved during the surgery. Fifteen hundred cc. of whole blood were given as a transfusion. The patient's recovery was again complicated by atelectasis and bronchopneumonia which responded to penicillin and CO<sub>2</sub> inhalation. She left the hospital on the 9th post-operative day.

The fourth pregnancy resulted in spontaneous abortion from the remaining left uterus.

CASE 7. An 18-year-old para 0, gravida I at 35 weeks gestation was found to have a frank breech presentation, a double cervix and vaginal septum. She was delivered by breech extraction after a 6 hour labor at 36 weeks gestation. The septum offered no difficulty. Baby living. Third stage uneventful.

### Summary

These seven cases represent a total of 16 pregnancies. These pregnancies resulted in the following known or observed complications:

6 Premature labors.

5 Abortions, 3 with curettage and 2 without curettage

1 Missed abortion without curettage

1 Cesarian section

1 Ruptured uterus with dead baby, right hysterectomy

2 Occipito-sacral positions

3 Breech presentations

3 Manual removals of placentae

As a result of 16 pregnancies only seven living infants were obtained. It has been demonstrated that gross congenital anomalies of the genital tract predispose to abnormalities of pregnancy, labor, and delivery.

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## ELMER L. HENDERSON, A CAPABLE LEADER

Dr. Elmer L. Henderson's term as President of the AMA is now history. It fell Dr. Henderson's lot to serve as the leader of organized medicine in America during an epochal and history-making period, when the very foundations of the structure of medicine were seriously threatened. The opponents were of a stature that would have intimidated a less intrepid individual. But not Dr. Henderson. His fearlessness coupled with a determination to preserve Americanism in the practice of medicine proved to be a winning combination. The victory was won at the grass roots level on the battleground of public opinion. That his efforts were appreciated was evidenced by an almost unparalleled round of applause by the House of Delegates when it was announced that he would remain in charge of the activities of the Education Campaign Committee.

Dr. Henderson is intensely loyal to the medical profession. He is jealous of its prerogatives. Perhaps more than any other leader of medicine he has recognized "the price of Freedom is eternal vigilance." One less vigilant would have been

taken by surprise on many occasions since all of the threats to medicine have not been straightforward and obvious but were obscured by subtlety. Numbers of such were ferreted out, exposed, and overcome. President Truman in his address on the occasion of the laying of the cornerstone of the Clinical Center at Bethesda in June showed clearly that the issue of socialized medicine is neither dead nor forgotten by its proponents. It is a sleeping beast. Dr. Henderson has said that the profession has won two years of grace in which gains won must be consolidated.

As valiantly and as successfully as Dr. Henderson has fought, his efforts would have left a great deal to be desired if all that could be said was that he has spent his year in opposition to something. This has not been the case. Many constructive actions have been taken by the AMA and much progress has been made by state associations through AMA's leadership that have cemented the profession's relations with the public.

This service to medicine has not been rendered without personal sacrifice by



Dr. Henderson. During the year of his presidency, he was absent from his practice more than half of the time. He has traveled more than 100,000 miles. He has attended countless meetings all over the world.

At the beginning of his term of office as President, we said that the Association's affairs were in capable hands. His actions have justified this statement and he has served in such a way as to bring credit to himself and honor to Kentucky.

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## CHANGES IN HOSPITALIZATION OF CRIPPLED CHILDREN

Certain changes in the organizational structure of the National Foundation for Infantile Paralysis have affected the working relationship between the Foundation and the Kentucky Crippled Children Commission, particularly in regard to payment for hospitalization. Dissolution of the Charter of the Kentucky Chapter by the National Foundation terminated the working agreement on July 1, 1951 that had been in effect for ten years whereby the Commission, acting in the capacity of agent for the Kentucky Chapter, was empowered to give hospitalization, medical care and other necessary treatment for all cases of poliomyelitis over the entire state. In the future the Commission must limit such services to

those patients who are less than twenty-one years and who are eligible under the economic restrictions specified in the Kentucky Statutes.

Determination of eligibility for financial assistance from the Foundation for the payment of medical care will be made by County Chapters of the Foundation as soon as the Chapters start functioning and are able to assume the responsibility.

No change has been made in the method of referring eligible children who are in need of orthopedic treatment to the Commission. Referrals should be made to Miss Marian Williamson, Director, The Kentucky Crippled Children Commission, 302 Heyburn Building, Louisville.

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## PROGRESS IN KENTUCKY'S BLUE SHIELD PLAN

It was with some trepidation that twenty-five thousand dollars was taken from the treasury of Kentucky State Medical Association less than two years ago and trustingly deposited to the account of a brand new corporation, Kentucky Physicians Mutual, Inc. By that action the medical profession in Kentucky demonstrated in a most practical manner that it was sincerely interested in preserving the future of medicine by providing a voluntary method for prepayment of medical care. This step culminated five years of research and work by the committee which was led by Dr. Oscar O. Miller and authorized and sanctioned by the Council and the House of Delegates.

The faith of these leaders has proved to be well founded. Kentucky's Blue Shield plan is rapidly growing. During the first quarter of this year, it led all of the plans in the Nation in the 50,000-100,000 member class in growth both percentage-wise and numerically. 15,941 members were gained during the period,

constituting a 29.45 per cent increase. The sum advanced by the association has been repaid. The financial condition of the company is excellent. The rate structure has proved actuarially sound. Plans are being made to remove inequities in the schedule of indemnities by setting higher payments for some procedures which will be done without any increase of rates and will give subscribers an even better bargain.

The greatest advance is the issuance of the new contract to any individual who is 65 years of age or under and who is in good health thereby cancelling the requirement that subscribers must be members of an employed group in order to be eligible. This individual contract offers coverage to practically every Kentuckian and immeasurably broadens the scope and utility of the plan.

Attractive informative material especially designed for prominent display has been mailed to participating physicians and to hospitals. Business reply cards for the convenience of interested persons were in-

cluded. Doctors' offices are ideal locations for these displays since patients are naturally interested in the economy of medical care. Then too, it is the Doctors' Plan, initiated and actively sponsored by the profession.

Participating physicians are asked to display the material in a convenient loca-

tion in the waiting room.

Kentucky's doctors are continuing to cooperate with the plan in a fine way. The total number of counties in which a majority of physicians are participating now stands at 95 and only 52 more signatures are required for state-wide sale of the contracts.

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## EDITORIAL COMMENTS

**An advisory committee has been appointed to assist AMA in handling some of its public relations problems.** The committee consists of eight executive secretaries and public relations directors of state medical associations. AMA's public relations director, Leo Brown, said that "the fundamental purpose of the committee is to give counsel as to how AMA can best serve state and county societies in the field of public relations." We heartily approve of this attempt to bring the viewpoint of state associations to the national level. We believe that a closer contact between the two will result in an improved situation.

**Some of the newer, potent organic insecticides are being sold and recommended for use in home gardens.** Tetraethyl pyrophosphate and formulae containing parathion are among them. These materials may be absorbed by inhalation, ingestion, absorption through the mucosa of the eyes and through the skin. They act as nerve poisons, causing an irreversible inhibition of cholinesterase. Symptoms may include headache, excessive sweating, giddiness, blurred vision, weakness, nausea, cramps, diarrhea, and discomfort in the chest. Signs include sweating, constriction of the pupils, epiphora, excessive salivation, cyanosis, convulsions, coma, loss of reflexes, and loss of sphincter control. Laboratory findings may be normal except for a lowering of the blood cholinesterase level.

Treatment consists of keeping patients fully atropinized when symptoms appear. One to two mg. of atropine intramuscularly every hour, or more frequently if necessary, is recommended by U. S. Public Health Service. This high dosage is said to be safe and may be lifesaving. Full atropinization may be necessary for several days. Morphine should not be used.

Postural drainage and aspiration may be necessary to keep the airway clear. The administration of oxygen under slight positive pressure may be required in addition to continuous oxygen in the usual manner.

The effects of organic phosphates are additive and if recovery of the cholinesterase level is not complete, further exposure may be rapidly fatal.

References: U.S.P.H.S. memorandum dated June 11, 1951.

J.A.M.A., Vol. 144, pp 104-108, 1950 (Sept. 9).

**Several state associations have gone all out in urging doctors to itemize their statements.** Physicians would not like to receive a statement from supply houses, "Supplies Furnished, \$301.25"; or from their garageman, "Auto Repair, \$80.50." They would want to know, "What supplies?"; "How much for auto repair parts?"; "How much for labor?"

So it is when a patient gets a statement, even abbreviated to "Prof. Serv. \$75.00."

The Illinois State Medical Association suggests, "Think it over. Put yourself in your patient's shoes and see if they pinch—just a little."

**The supply of physicians in the United States** was the subject of a rather hot spontaneous debate in the House of Representatives recently. It was touched off during consideration of a bill authorizing 24 new VA hospitals and additions to 14 existing ones, totalling 16,000 additional beds at an estimated cost of 35 million dollars.

One representative (Rabaut—D., Mich.) said, "The real trouble with this country seems to be a shortage of doctors." Representative Graham Borden (D.-N. C.) criticized the Army for placing older and more experienced physicians in adminis-



trative jobs. "They better move those doctors into the operating rooms . . . and let someone else do the administrative work as any other well-run civilian hospital would do," he said. Representative Edith Rogers (R.-Mass.) stated, "If they would stop drafting doctors . . . VA would have plenty of doctors." Representative John Wood, who is a physician, replied that what was needed is "to use the doctors they have in veterans hospitals more intelligently and stop putting in more people who should be in other institutions than hospitals."

The House went right along and authorized the additional beds after Representative Carl Anderson (R.-Minn.) read a report from VA which expressed "considerable concern" over the problem of staffing the new hospitals with medical personnel.

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**Scrub typhus proved almost as dangerous** to American troops in the Pacific in World War II as the enemy. The Army Medical Service is sending for the fourth time a research team into the Malay states and British North Borneo to study means of control. Former teams have reported that the newer antibiotics have proved to be highly effective therapeutic agents. Chloromycetin, aureomycin and terramycin were considered to be the drugs of choice in the order named.

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**AMA's House of Delegates adopted a resolution** favoring federal financial aid to medical schools for construction only, based on a formula similar to the one used for Hill-Burton Hospital Construction.

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**The Department of the Army has issued regulations** concerning civilian medical care of Army personnel. Such care is authorized at Army expense for officers and enlisted men when on approved leave or when on duty status in vicinities where there are no federal medical treatment facilities available. First aid or emergency treatment (required to save life, limb or prevent great suffering) is authorized at any time. Surgical operations should not be performed without prior approval of military authorities. The surgeon of the nearest military com-

mand should be immediately notified following emergency treatment without authorization. Bills for authorized care should be sent to the authorizing authority, to the patient's commanding officer, or to The Surgeon, Second Army, Fort George G. Meade, Maryland.

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**A team of military and civilian experts** who spent a month in Japan and Korea studying frostbite cases have recommended improved methods of treating this type of injury.

Principal methods suggested include rest in bed, no smoking, daily foot care with a mild, non-irritating cleansing agent, a hospital ward temperature maintained between 72 and 78 degrees, the use of penicillin during evacuation for treatment and employment of other antibiotics during treatment, and the delay of surgery until there is no question of demarcation of the affected part.

Studies in rapid thawing of the frozen part, regional and general dilatation of blood vessels, anticoagulants, and abstinence from tobacco will be carried out at the Army Medical Research Laboratory at Fort Knox.

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**Ground-breaking ceremonies for the new Armed Forces Institute of Pathology** were held at the Army Medical Center in Washington on July 10. The Surgeon Generals of the United States Army, Navy and Air Force, the Surgeon General of the Public Health Service and the Chief Medical Director of the Veterans Administration were speakers.

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**The hospitalization of indigents** who are not able to pay becomes in most instances an increased hospital operating cost that is eventually reflected in charges to patients who pay their bills. Although this is understandable it results in a situation that is unfair to the patient whose hospital expenses are enough of a burden without having to shoulder the cost of indigent care. County fiscal courts have an obligation in this regard that is placed upon them by Kentucky Statutes that is too often ignored or only partially complied with. Complete compliance with law by fiscal courts would go a long way toward meeting the problem.

# ORGANIZATION SECTION

## Centennial Session to Memorialize Ephraim McDowell

The Council of the Kentucky State Medical Association has designated our forthcoming gathering as the Ephraim McDowell Memorial Meeting. It is most fitting that in celebrating the Centennial of our organization next October we again pay tribute to Kentucky's most distinguished surgeon.

At our second meeting in 1852, Dr. Samuel D. Gross presented an exhaustive history of the surgeons of Kentucky and their accomplishments. Almost one fourth of his report dealt with McDowell. This contribution was first printed in our **Transactions** for 1852 and later reprinted in book form. It had much to do with giving tardy recognition to McDowell.

As early as 1874, a movement was started to collect funds for the erection of a monument and, in April 1876, the McDowell Monument Committee was appointed with the late Dr. Lewis S. McMurtry, then of Danville, as Chairman. By aggressive action this Committee secured sufficient funds for the erection of a monument which was unveiled during our meeting in Danville on 14 May 1879. Dr. Samuel D. Gross was the principal speaker.

Since that time sporadic efforts were made to purchase the house in which McDowell lived and performed his celebrated operation in 1809. Finally our Association was successful in buying the building and grounds which were presented to the Commonwealth of Kentucky on 20 May 1939. The Division of Parks of the Commonwealth with the assistance of the Works Progress Administration restored the house to its original state. Unfortunately it was refurnished only partially and failed to attract a sufficient number of visitors. Because of this, the Commonwealth returned the property to the Kentucky State Medical Association in 1947.

A McDowell House Committee is now actively engaged in obtaining funds for the completion of the furnishing of the house and its endowment as a national shrine. It is hoped that by honoring McDowell at our Centennial sufficient impetus may be given to their efforts to insure success. Surely every member of our Association will feel himself responsible for a part in the laudable undertaking of the McDowell House Committee.

Emmet F. Horine.

## Scientific Exhibits to Cover 300 Feet at Centennial Session

Approximately 25 carefully chosen, highly profitable scientific exhibits, covering the various fields in Medicine, will be one of the main features of the Centennial Meeting, October 2, 3 and 4, the Committee on Scientific Exhibits reports.

Over 300 feet of wall space assigned for this purpose at the Columbia Auditorium will feature many out-of-state exhibitors and will include such national organizations as the Atomic Energy Commission, U. S. Army, The Army Air Force, and Northwestern University.

The Committee on Scientific Exhibits has been very active and has not spared effort or expense in setting up this outstanding scientific exhibit.

## Collection of Centennial Papers, Features To Be Published

A volume to be edited by Emmet F. Horine, M. D., Brooks, and planned by the Centennial Committee, will be published in connection with the Centennial Celebration of the Association.

While it will not be possible to have the volume ready at the time of the Centennial, every effort will be made to have a bound facsimile on display at that time so that members may see and place orders for it.

The volume will carry a brief history of the first one hundred years of the Association, a brief sketch of the life of Ephraim McDowell and pictures of the presidents of the Association. In addition it will carry a biographical sketch, picture and essay of each of the guest speakers at the Centennial.

## Allied Professions to Participate in Centennial Historical Exhibits

The four allied professions along with the Kentucky State Department of Health will participate in our Centennial celebration by having historical exhibits showing the progress each profession has experienced over the past one hundred years, William R. McCormack, M. D., Bowling Green, Chairman of the Centennial Sub-Committee on Historical Exhibits, announced.

The Kentucky State Dental Association,



Kentucky Hospital Association, Kentucky State Association of Registered Nurses, and the Kentucky Pharmaceutical Association, along with the Kentucky State Department of Health, have accepted invitations to have exhibits.

According to Dr. McCormack, the exhibits will be set up in the attractive rooms immediately to the right of the main entrance of the Columbia Auditorium and will be open during the entire Centennial Meeting of the Association, October 2, 3 and 4.

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### **Youngest Physicians To Be Drafted First Under Public Law 779**

Physicians registered under Public Law 779 (sometimes referred to as the Doctor Draft Act) will be called into Service according to their birth dates—the youngest going first—Howard A. Rusk, M. D., Chairman of the National Advisory Committee to Selective Service, has announced.

The Kentucky Procurement Committee is interested in having our Kentucky physicians, who are subject to induction, acquainted with this information. Public Law 779 makes it mandatory that the registrants be inducted on a basis of age, with the youngest called first.

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### **Auxiliary to Set Up KSMA Historical Exhibit at Centennial**

The historical exhibit of the Association—depicting one hundred years of medical progress—will be set up and presented at the Centennial Meeting, October 2, 3 and 4, by a special committee of the Woman's Auxiliary to the State Association, in cooperation with the Centennial Sub-Committee on Historical Exhibits.

Mrs. Clark Bailey, Harlan, President of the State Auxiliary, at the request of W. R. McCormack, M. D., Bowling Green, Chairman of the Sub-Committee on Historical Exhibits, has named the Auxiliary committee that will have this responsibility. Mrs. Malcolm Barnes, Louisville, is Chairman and serving with her are Mrs. Irving Gail, Lexington, and Mrs. Walker Owens, Mount Vernon.

The committee, as this was written, had met twice and developed plans for the historical exhibit that will be staged at Columbia Auditorium. Mrs. Bailey and members of the committee are enthusiastic about the plans for this historical phase of the Meeting and promise a most interesting display, Dr. McCormack said.

### **Twelve Kentucky Doctors Receive "Greetings" From S. S.**

Twelve Kentucky physicians received "greetings" from their local Selective Service boards late in June and were ordered to report for induction by July 25, the Procurement Committee has learned.

The call came to Selective Service from the Second Army in order that the quota for Kentucky for July might be met. No quota for August had been announced as this is written.

According to information available at press time, all but four of the twelve doctors had applied for commissions. While latest radio reports indicate that no inductions will take place at this time, quotas must be kept filled by voluntary enlistments. Eventually, by law, all Priority I men (not deferred or physically disqualified) must volunteer or be inducted before Priority II, III, or IV men are conscripted.

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### **Sale of 64 Technical Exhibit Spaces Tops 1950 Record By Nine**

All space in the technical exhibit hall for the Centennial Meeting, October 2, 3 and 4, at the Columbia Auditorium, Louisville, have been sold, Carlisle R. Petty, M. D., Chairman of the Technical Exhibit Committee, has reported.

Dr. Petty said that due to reorganization of space, there will be nine more technical exhibits at the Centennial Meeting than the 55 spaces sold for the 1950 meeting.

"When we realize that in many instances our bordering sister state associations, having three and four times our membership, range from 65 to 80 technical exhibitors each year, we cannot help but be most grateful for the support of our family of 64 exhibitors for the Centennial Meeting," Dr. Petty stated.

The Technical Exhibit Committee urges all members attending the meeting to plan to visit each exhibit.

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### **Dr. Wolfe to Head Centennial Golf Group**

K.S.M.A. members addicted to the ancient pastime of playing golf should bring their clubs with them when attending the Centennial Meeting in Louisville, October 2, 3 and 4, William C. Wolfe, M. D., Louisville, Chairman of the Centennial Golf Committee, has announced.

Other members of the committee are George W. Pedigo, M. D., and Leo W. Zimmerman, M. D., also of Louisville. This committee was ap-

pointed by Sam A. Overstreet, M. D., Louisville, President.

Dr. Wolfe asks the doctor golfers to read the September issue of this Journal for particulars on the Centennial Golf Tournament.

### **Priority I Physicians To Meet Armed Forces Needs Thru 1951**

Latest estimates of medical manpower needs, officials in Washington announced, indicate that on the basis of present demands the pool of physicians in Priority I should supply the needs of the Armed Forces until 1952, according to a statement by the Chairman of the Kentucky Procurement Committee, A. Clayton McCarty, M. D., Louisville.

These same sources, Dr. McCarty said, estimate that enough men are registered in Priority II to take care of the early part of 1952, and a sufficient number in Priority III to last until 1953. This being true, men in Priority IV would not be subject to call until after January, 1953, according to present manpower estimates.

### **Dr. Morse Appointed Chairman of The Diabetic Committee**

Carlisle R. Morse, M. D., Louisville, has been appointed Chairman of the new Diabetic Committee of the Association, Sam A. Overstreet, M. D., President, has announced.

Other members of the committee named by Dr. Overstreet are George N. Burger, M. D., Covington; William P. Hall, M. D., Paducah; Frank H. Moore, M. D., Bowling Green; and Martin Palmer, M. D., Hazard.

Among the duties of this committee, which was activated by the Council, is to direct the Association's activities in its participation in the National Diabetic Detection effort.

### **Collier's Carries Article On Color X-Ray By Dr. Pirkey**

The July 21st issue of Collier's magazine carried an article by Everett L. Pirkey, M. D., Head of the Department of Radiology, University of Louisville School of Medicine, with four color illustrations, demonstrating his adaptations of a commercial photographer's process for the coloring of X-rays.

"By means of this process, we are able to emphasize any particular part of an X-ray we desire. The sole use of this method is for teaching purposes, and, as such, it has proven quite valuable in selected instances," Dr. Pirkey said. He pointed out the method is still in the development stage.

### **KSMA Well Represented At Atlantic City AMA Session**

Retiring President Elmer L. Henderson, M. D., and delegates from the Kentucky State Medical Association, J. Duffy Hancock, M. D., J. B. Lukins, M. D., and Bruce Underwood, M. D., all of Louisville, were among the approximately ninety members of this Association to attend the Atlantic City Meeting of the American Medical Association, June 11-15, 1951.

A total of 12,229 physicians registered this year along with 16,167 guests, for a total of 28,396. The San Francisco Meeting in 1951 registered 10,241 physicians and had a total attendance of 23,777. The record A.M.A. attendance was made in 1947 at the Centennial when 15,667 physicians registered.

At the Annual Meeting, which officials described as "an outstanding success," 358 scientific papers were presented, 297 scientific exhibits and 350 technical exhibits were set up, 37 motion pictures were seen and 17 television demonstrations given. Addresses by John W. Cline, M. D., San Francisco, incoming president, and Dave Beck, nationally prominent labor leader, were broadcasted over a nation-wide radio hook-up.

In addition to those listed above, it is known the following Kentucky doctors registered: Rufus C. Alley, M. D., Lexington; S. Spafford Ackerly, M. D., Louisville; Henry B. Asman, M. D., Louisville; F. G. Aud, M. D., Louisville; John T. Bate, M. D., Louisville; Clark Bailey, M. D., Harlan; Joseph C. Bell, M. D., Louisville; Israel R. Berger, M. D., Louisville; Samuel J. Brownstein, M. D., Louisville; J. A. Bowen, M. D., Louisville; W. O. Bullock, M. D., Lexington; J. R. Buskirk, M. D., Louisville; W. H. Cartmell, M. D., Maysville; Misch Casper, M. D., Louisville; Oscar L. Cawood, M. D., High Splint.

O. T. Davis, M. D., Owensboro; Irving O. Dein, M. D., Louisville; Murray A. Diamond, M. D., Lexington; Robert S. Dyer, M. D., Louisville; Joshua Erlich, M. D., Louisville; O. T. Evans, M. D., Lexington; David C. Fainer, M. D., Fort Knox; John B. Floyd, Jr., M. D., Lexington; E. R. Gernert, M. D., Louisville; C. F. Haley, M. D., Brooksville; Horace Harrison, M. D., Owensboro; John S. Harter, M. D., Louisville; C. C. Howard, M. D., Glasgow; Richard T. Hudson, M. D., Louisville; Arthur T. Hurst, M. D., Louisville.

Stello Imprescia, M. D., Louisville; V. A. Jackson, M. D., Clinton; Boyce E. Jones, M. D., London; R. D. Joplin, M. D., Louisville; Max D. Klein, M. D., Louisville; Nathan Levene, M. D., Louisville; Ralph D. Lynn, M. D., Elkton; William K. Massie, M. D., Lexington; Arthur Clayton McCarty, M. D., Louisville; Oscar O.



Miller, M. D., Louisville; Robert F. Monroe, M. D., Louisville; Frank H. Moore, M. D., Bowling Green; William Ray Moore, M. D., Louisville; C. A. Morris, M. D., Covington; Maurice Nataro, M. D., Louisville.

C. Wyatt Norvell, M. D., Lexington; Earl P. Oliver, M. D., Scottsville; Alvin B. Ortner, M. D., Louisville; H. Oppenheim, M. D., Outwood; Paul S. Osborne, M. D., Louisville; Kenneth D. Orr, M. D., Fort Knox; Sam A. Overstreet, M. D., Louisville; Harlen M. Parker, M. D., Louisville; Alfred P. Peretti, M. D., Corbin; Carl Pigman, M. D., Whitesburg; Cwen Pigman, M. D., Whitesburg; Everett L. Pirkey, M. D., Louisville; M. H. Fulskamp, M. D., Louisville; B. F. Radmacher, M. D., Louisville; Edward H. Ray, M. D., Lexington.

Ben A. Reid, M. D., Louisville; Clifton Richards, M. D., Glasgow; Paul A. Robinson, M. D., Covington; Ephraim Roseman, M. D., Louisville; William L. Ross, Jr., M. D., Lexington; Gracie R. Rowntree, M. D., Louisville; Marjorie Rowntree, M. D., Louisville; James A. Ryan, M. D., Covington; Jack C. Sallee, M. D., Lexington; Joseph Schickel, M. D., Burnsville; Arthur M. Schoen, M. D., Louisville; John W. Scott, M. D., Lexington; Col. Fred W. Seymour, M. D., Fort Campbell; David Shapiro, M. D., Louisville; Paul J. Sides, M. D., Lancaster.

Eldridge C. Simmons, M. D., Camp Breckinridge; Truman S. Smith, M. D., Corbin; L. H. South, M. D., Louisville; Maher Speevack, M. D., Munfordville; J. Frank W. Stewart, M. D., Waverly Hills; Frank P. Strickler, M. D., Louisville; F. M. Travis, M. D., Frankfort; Woodford B. Troutman, M. D., Louisville; Karl D. Winter, M. D., Louisville; and Makato Yamaguchi, M. D., Fort Thomas.

### **Dr. Bauer Named President-Elect By A.M.A. Delegates**

Louis Hopewell Bauer, M. D., Hempstead, N. Y., who has been chairman of the Board of Trustees for the past two years, was unanimously chosen as President-Elect of the American Medical Association by the House of Delegates in its final session at Atlantic City in the Traymore Hotel, Thursday, June 14.

In his acceptance speech delivered before the House shortly after his election, Dr. Bauer called attention to the responsibility of the medical profession, and stated the world "is watching closely the actions of this body."

He said, "Doctors and medical societies should be leaders, broad-minded and forward thinking. Medicine is humanitarian and the needs of the people must come first. There is no room in medicine for the selfish doctor who thinks only of himself and his income."

Born in 1888 and graduating from Harvard in 1912, Dr. Bauer reached the rank of Lt. Colonel in World War I. After holding various offices in his county and state medical organizations, he was elected to the A.M.A. House of Delegates in 1938, and was made a member of the Board of Trustees in 1941. He is now serving as Secretary of the World Medical Association.

Dr. Bauer will take office at the 1952 Annual Meeting in Chicago.

### **AMA House of Delegates Has Full Agenda at Atlantic City**

Kentucky's delegation to the American Medical Association House of Delegates, Drs. J. Duffy Hancock, J. B. Lukins and Bruce Underwood, participated in one of the busier sessions of that organization at the June Atlantic City meeting. Some of the more important actions of the House follow:

Several resolutions seeking the abandonment of the Fellowship in connection with A.M.A. dues were introduced. The House adopted the report of the reference committee which approved of the principle but felt that abandonment of the Fellowship deserved further study. The matter was referred to the standing committee of the House on Constitution and By-Laws with instructions to prepare such changes in the Constitution and By-Laws, in consultation with the Board of Trustees, as were thought desirable and report to the House at its next meeting.

Annual dues for 1952 were set at \$25.00 and will include the weekly A.M.A. Journal.

A resolution was adopted supporting federal financial aid to medical schools for construction only. The resolution called for operation of the plan on the same formula as used in the Hill-Burton Hospital Construction Act.

Another action by the House authorized the expansion of the A.M.A.'s Physician Placement Service, and urged the various state medical associations to do the same.

Accreditation of hospitals received the careful attention of the House. It adopted a recommendation calling for the creation of a national joint commission on accreditation by "the American College of Physicians, American College of Surgeons, the American Hospital Association and the American Medical Association. A report and recommendations for the various interested groups has been proposed by committees from each organization. The joint findings will be acted on by the four associations before they can be accepted as the guiding principles for a national joint commission on accreditation of hospitals."



John W. Cline, M. D., left, is congratulated following his inauguration as A.M.A. President by Louis H. Bauer, M. D., right, the Chairman of the A.M.A. Board of Trustees, as Elmer L. Henderson, M. D., retiring President, looks on at the Atlantic City meeting, June 11 to 15. Dr. Bauer was unanimously elected President-Elect two days later by the House of Delegates.

Photograph—courtesy of A.M.A. Chicago office.

### Dr. Cline Succeeds Dr. Henderson As A.M.A. President

Succeeding Elmer L. Henderson, M. D., Louisville, John W. Cline, M. D., San Francisco, was inaugurated as President of the American Medical Association before an audience estimated at more than 5,000 in the giant auditorium at Atlantic City, June 11, 1951.

Dr. Cline, in his inaugural address which was broadcasted on two national radio networks, stated, "No health crisis or medical emergency exists in this country." The problem is not a shortage of physicians but a proper distribution of them.

The incoming president felt that these problems were being solved by cooperation of the medical organizations and lay groups. He

pointed out that the A.M.A. and state and county societies are assisting communities needing doctors to find them.

"The number of physician graduates by 1960 will be increased 30% over 1950," Dr. Cline stated as he called for the maintenance of the highest standards in medical teaching.

Stating a baby born today has a 45% greater chance of reaching the age of 50 than he had in 1900, Dr. Cline said, "I believe the mothers of America will consider these achievements far outweigh the empty promises of those who urge a system of government-controlled medical care."

Dr. Cline touched on many of the services rendered by the A.M.A. and urged greater support of Voluntary Health plans by the Medical Profession.



### **Dr. Henderson Reports to A.M.A. House On Education Foundation**

Elmer L. Henderson, M. D., President of the American Medical Education Foundation, made a most effective presentation of the need for financial support for the medical schools of the country, before the final session of the A.M.A. House of Delegates.

Dr. Henderson urged each state medical association and county medical society to consider this obligation, pointing out that New York is to raise \$250,000, California has contributed \$100,000 and South Carolina has raised \$10,000. He asked each member to contribute \$100.00 a year, or as much as he felt he could give.

It was pointed out that these contributions were deductible from Federal income taxes, and that the contributor could designate the school to which he wanted his money given.

Dr. Henderson also announced gifts to the Fund in the amount of \$10,000 from the Woman's Auxiliary to the A.M.A., and \$2,000 from the American College of Radiology.

### **Dave Beck Address to A.M.A. House Carried On Radio Network**

Dave Beck, Executive Vice-President of the International Brotherhood of Teamsters of the American Federation of Labor, took a strong stand against the socialization of medicine before the House of Delegates at a dinner meeting, June 11, 1951, during the Atlantic City Session.

"The answer to the problem of medical care will not be found in any political panacea or through the development of a super-bureaucracy," the labor leader told the House. "The answer as proposed by advocates of government control of medicine is contrary to our economic structure and goes beyond our traditional guarantees."

Mr. Beck's speech was carried by a 100-station radio network. At the Cleveland session of the House of Delegates last December 7, an address by William L. Hutchins, General President of the United Brotherhood of Carpenters and Joiners, denouncing "government medicine" was broadcasted over a nation-wide radio network.

Mr. Beck stated he had been abroad and studied government-sponsored medical care systems and said he had seen its failure at first hand. He championed the right of the patient to call the physician of his choice.

"A tremendous responsibility rests upon us all to see that we continue, expand and improve our voluntary medical care program," Mr. Beck said.

### **Whitaker and Baxter to Be Retained**

President Elmer L. Henderson, in his report to the House of Delegates at the opening session during the Atlantic City Meeting, stated that "The Campaign Coordinating Committee and the Board of Trustees, acting on the recommendation of Clem Whitaker and Leone Baxter, have decided to terminate the National Education Campaign at the end of this year."

Later during the convention, however, several resolutions were introduced asking that the Board of Trustees continue to engage Whitaker and Baxter's services for another year. The Board reconsidered the matter and agreed to employ the public relations firm on a half-time basis for 1952.

At the last session of the House, it was announced that the Campaign Coordinating Committee would be continued. When it was stated that Dr. Henderson had agreed to serve once more as its Chairman, there was hearty applause by the delegates.

### **Program On Atomic Illness Given Before Third District June 12**

The Third Councilor District met jointly with the Christian County Medical Society at the Western State Hospital in Hopkinsville on June 12, 1951.

A program on the treatment of atomic illness was presented by Robert M. Coleman, M. D., Hopkinsville, and Roy H. Moore, Jr., M. D., Louisville. A film was included in the program.

The doctors were the dinner guests of Floyd K. Foley, M. D., superintendent of the Western State Hospital. Delmas M. Clardy, M. D., Hopkinsville, is Councilor for the district, and President of the Christian County Society.

### **Fourth District Hears Four Papers At Bardstown Meeting**

Four scientific papers featured the annual meeting of the Fourth Councilor District at the Bardstown Country Club, June 27, 1951, according to J. I. Greenwell, M. D., Councilor for the district.

Sam A. Overstreet, M. D., Louisville, President of K. S. M. A., brought greetings from the Association to the forty-five physicians and their wives who were in attendance. The Nelson County Medical Society was the host group.

The scientific program was given by the following physicians: C. C. Howard, M. D., Glasgow, and Jack L. Chumley, M. M., George McAuliffe, M. D., and W. W. Nicholson, M. D., all of Louisville.

## Student AMA Delegates Make History

History was made at the A.M.A. opening session of the House of Delegates at the Atlantic City meeting when two students were recognized as delegates of the newly formed Student A.M.A. and seated.

Warren R. Mullen of the University of Michigan Medical School and Harry W. Sanberg of the University of Illinois College of Medicine were the first to represent the Student A.M.A.

The University of Louisville Student Medical Society, which has 150 members, is a charter member of the Student A.M.A. Charles McGaff is President of the local group.

## Forty-Five Attend Twelfth District Session at Somerset

Meeting on the shore of beautiful Lake Cumberland, the new Twelfth Councilor District held its first annual dinner at the Lee Ford Dock, Somerset, June 27, Carl Norfleet, M. D., Somerset, Councilor, announced.

J. D. Winebrenner, M. D., Knoxville, Tennessee, was the guest speaker on the program. Other essayists were Charles P. Salyer, M. D., Burnside, and Robert C. Bateman, M. D., Somerset. The forty-five physicians attending the meeting were welcomed by A. B. Morgan, M. D., Somerset, President of the Pulaski County Society.

Prior to the dinner, members of the Pulaski County Society—the host society—conducted some of the visiting physicians on a tour of the lake region. Other visitors were taken on motorboat rides.

## Sixty-Five Attend Seventh District Session at Frankfort

Sixty-five physicians and their wives attended the first annual meeting of the new Seventh Councilor District at the Frankfort Country Club, June 28, 1951, B. B. Baughman, M. D., Councilor, stated.

Edgar S. Weaver, M. D., Carrollton, was elected President; R. N. Lawson, M. D., Lawrenceburg, Vice-President; and W. P. Snyder, M. D., Frankfort, Secretary, when the district organized following the scientific session.

Scientific papers were presented by O. James Hurt, M. D., Bedford, and Glenn E. McMunn, M. D., Eminence. Lenora P. Chipman, M. D.,

Williamstown, was scheduled to give a paper but was unable to do so because of illness. The Franklin County Medical Society was host to the meeting.

## Dates of Future AMA Sessions Listed

K.S.M.A. members who plan to attend future meetings of the American Medical Association will be interested in the schedule for the next three years.

The Clinical Session for 1951 will be held at Los Angeles, December 4-7.

The 1952 Annual Meeting will be held in Chicago, June 9-13, and the Clinical Session at Denver, December 1-5, 1952.

The 1953 Annual Meeting is scheduled for New York City, June 1-5, and the Clinical Session, December 1-4, at St. Louis.

The 1954 Annual Meeting will be staged at San Francisco in June, and the Clinical Session in December at Miami, Florida.

## Dr. Whipple Voted A.M.A. Medal

Allen C. Whipple, M. D., a New York City surgeon, was chosen the winner of the 1951 Distinguished Service Medal by the A.M.A. House of Delegates at its opening session at the Traymore Hotel in Atlantic City, Monday, June 11, 1951.

The award, which is made annually to a Fellow of the A.M.A. for outstanding service, went to Dr. Whipple for his work in the field of gall bladder and pancreas surgery. Born of missionary parents in Persia in 1881, Dr. Whipple received his medical education at Columbia University and has spent his medical career in New York.

Major General Harry G. Armstrong, Surgeon General of the U. S. Air Force and graduate of the University of Louisville Medical School, ran a close second to Dr. Whipple in the elections by the House.

## New Members Welcomed

We welcome the following new members to the Association, who joined during the month of June: Daviess County—John E. Bickell, M. D., Owensboro.

Jefferson County—Jean Graves Blodgett, M. D., Louisville.

Whitley County—Lewis B. Clayton, M. D., Corbin.



## *Pertinent Paragraphs*

The A.M.A. Board of Trustees has accepted an invitation from the officers of the American Hospital Association for a discussion of hospital-physician relations.

A symposium on peptic ulcer will be held at the Daniel Boone Hotel in Charleston, West Virginia, at 1:30 P. M., October 3, 1951. The program will be presented by members of the faculty of the Duke University School of Medicine. Registration fee of \$5.00 includes the dinner. Members of this Association are invited.

The Board of Trustees of the A.M.A. has announced the authorization of the appointment of a Committee on Nervous and Mental Diseases. The A.M.A. has not had a committee on mental health.

The Mississippi Valley Medical Society will hold its 16th Annual Meeting at the Pere Marquette Hotel in Peoria, Illinois, September 19-21, Harold Swanberg, M. D., Secretary, 209 W.C.U. Building, Quincy, Illinois, has announced.

Freshmen classes in medical schools in this country are 23 per cent larger in 1951 than in 1940. By 1960, the number of physicians will be 30 per cent greater than 1950, the Council on Medical Education told the A.M.A. House of Delegates in June at Atlantic City.

Keeping things straight at the A.M.A. Meeting means "getting around," George B. Larson, of the Bureau of Exhibits, found at Atlantic City. According to a pedometer, he walked 85 miles the first four days of the meeting.

Twenty-one U. S. Marine Hospitals operated by the Public Health Service, had their name changed July 1. They have been re-designated as U. S. Public Health Service Hospitals, Leonard A. Scheele, M. D., Surgeon General of

the Public Health Service, has announced.

The National Gastroenterological Association will hold a course in postgraduate gastroenterology at the Drake Hotel in Chicago, September 20-22. For information, write the Association at 1819 Broadway, New York 23, New York.

Dwight H. Murray, M. D., Napa, California, was elected Chairman of the Board of Trustees of the American Medical Association to take the place of Louis H. Bauer, M. D., Hempstead, New York, when Dr. Bauer was made President-Elect of the Association. David B. Allman, M. D., Atlantic City, was elected to fill out Dr. Bauer's unexpired term on the Board.

The 16th Annual Assembly of the U. S. Chapter of the International College of Surgeons will be held in Chicago, September 10-13. Headquarters for the meeting will be the Palmer House. Senator Estes Kefauver will address the final session of the Assembly in the Chicago Opera House.

A.M.A. members over 70 years of age may be excused from the payment of A.M.A. dues if they request it, regardless of local dues exemption, the House of Delegates decided at the Atlantic City meeting.

Attending the A.M.A. Atlantic City meeting were 42 lay secretaries of state medical associations and 27 lay secretaries of county medical societies.

Miss Hattie A. Niehoff, who has been employed by the American Medical Association for thirty-seven years, was honored with a dinner attended by more than 150 people, prior to the June Meeting at Atlantic City. Miss Niehoff will retire soon. The House of Delegates also paid tribute to her.

"The Mechel's Diverticulum," is the title of a paper printed in April issue of The American Surgeon, and written by Hal E. Houston, M. D., Murray, Kentucky. The paper was read before the Washington Assembly of the South-eastern Surgical Conference.

# President's Page

## THE SPIRIT OF OUR CENTENNIAL

The Kentucky State Medical Association is younger than that of some of our sister states, but its place in the Medical History of the United States is unique. We were gratified to learn what positions of prominence in so many leading medical institutions and schools are occupied by Kentuckians. A century ago Kentucky was a leader in medical education long before many of the southern schools had been established. Then the graduates of our schools were distributed widely throughout the entire south and southwest. Our tradition in medical education persists despite the fact that it has decreased considerably in relative importance. The contributions of Kentucky physicians and surgeons to the fund of medical knowledge has been significant. During its 103 years of life the American Medical Association has drawn more presidents from Kentucky than from any other state in the union.

While we pause this year to commemorate our past achievements and to reflect on our proud tradition we must realize that our primary concern must be in the future. Medicine is entering upon a new era and we must be atune to the conditions of the future rather than the glories of the past. This is a fine year for us to rededicate ourselves to our profession and to formulate a program for ourselves and the medical generations to follow.

Perhaps the first in necessity is Public Health. The changing financial condition, a shortage of trained Public Health Physicians, the limitation of salaries, and other factors have placed our traditionally fine Public Health Program under a serious strain. Means must be found to strengthen and extend this entire program throughout the state, particularly in the less populous counties which need Public Health measures most and can least afford them.

The problem of indigent medical care requires a better solution than we have been able to offer in the past. Some provision must be found to evenly distribute modern medical care to the indigent population in those areas which cannot afford to provide it for themselves. This applies particularly to hospitalization, medicines, medical appliances, the care of chronical-

ly ill and the aged. Physicians have always contributed their services liberally and will continue to do so, but food, clothing, shelter, hospitalization, and medication are commodities that must be bought and cannot be provided out of a doctor's bag.

Great progress has been made in the past few years in our crusade against tuberculosis and in the care of the tuberculous patients throughout the state. We must not relax in our efforts to carry this program forward with the greatest possible efficiency. The care of mentally ill is on a much sounder footing than before but requires the same constant diligence to maintain and expand the present services. We have made much progress in the care of crippled children. Little provision is made, however, for the spastic, the congenital heart invalid, the victim of rheumatic and other diseases leading to prolonged invalidism. This must be included in any constructive medical program of the future.

We must provide for the education of more doctors in Kentucky either by the enlargement of our present facilities or the establishment of another medical school. If we are able to educate and train in our own institutions those men and women from Kentucky who want to study medicine so that they will not be required to go to schools outside the state, we will retain a much larger number for practice here. While the demand for medical education is so much greater than our ability to supply it, most careful thought should be given to the selection of candidates. Inquiry into the ideals and objectives of a young man desiring to study medicine becomes quite as important as an appraisal of his scholarship in the elevation and maintenance of our professional standards.

Proud as we are of our past we must be more interested in where we are going than in whence we came. This is a profession of service to which men must dedicate themselves in a peculiar manner. We deal with life and death. We, as a profession, must take care that our public receive the best that can be given.

SAM A. OVERSTREET



# County Society Reports

## JEFFERSON

The May meeting of the Jefferson County Medical Society was held Monday evening, May 21, 1951, at the Seelbach Hotel. Sixty-seven members and guests were present for dinner, and about ten additional for the meeting.

The meeting was called to order at 8:05 p.m., by the President, Dr. Lytle Atherton.

Dr. Marion Beard introduced the guest speaker, Dr. Charles C. Ungley, Royal Victoria Infirmary, Newcastle-on-Tyne, England, whose subject was: "Macrocytic Anemia." The address was sponsored by the Louisville Society of Medicine.

The business meeting began at 8:45 p.m. The minutes of the previous meeting were read and approved.

Dr. L. M. Foltz, Chairman, Public Relations Committee, made an announcement regarding further plans for the dinner meeting for doctors' secretaries, sponsored by the Blue Cross-Blue Shield, and asked members' cooperation in supporting the new program of the Blue Cross which is being extended to include individuals beginning June 1. Dr. Foltz also urged physicians to listen to a new radio program to be heard over WAVE on Saturday, May 26, June 2 and June 9 at 4:30, which is being put on through the cooperation of the Health Information Foundation and NBC in the educational campaign to help people get medical care, and improve public relations between doctors and the public.

Dr. Alice L. Wakefield, Chairman, Professional Service Committee, reported on the committee's plans to reword the advertisement in the telephone directory to make it more specific; the possibility that an increased assessment for the service of the Physicians Exchange may be necessary; the need of more doctors to be available for emergency calls at night, and advisability of zoning the city, assigning certain doctors to districts for emergency night calls. The committee wished to know (1) whether the Society wishes to continue this ad for emergency medical service, and (2) whether members will give this activity sufficient support to justify working out plans.

Dr. Charles F. Wood made a motion that the committee be empowered to act as it sees fit in relation to changing the ad, and furthermore, in view of the fact that the Physicians Exchange had a surplus last year as well as

,previous years that they be empowered to spend that surplus in any way they see fit for the better functioning of the Physicians Exchange. Seconded. There was discussion by Drs. Foltz, Ray, Wakefield, Wood and Bloch. Dr. Charles F. Wood added to his motion: "If there is any additional lack of funds, that the lack be made up by the County Society." Motion carried.

The Secretary read a report from Dr. Joseph C. Bell, Chairman, Executive Committee, regarding communication from Dr. Schneider, stating it was the opinion of the committee that a separate assessment for the Library should not be considered at this time. Concerning hospital staff assessments for the support of hospital libraries, it was felt that the hospital library is the responsibility itself and not of the medical staff.

The application of Dr. John Walker Moore for transfer to Emeritus Membership was approved.

The following new members were elected:

Edgar B. Morgan to Associate Membership and Jean Graves Blodgett to Active Membership.

The Secretary read copy of a Resolution by the Association of American Physicians and Surgeons urging the American Medical Association to assume full responsibility for the professional and ethical standards of hospitals.

Dr. Charles F. Wood moved that this matter be referred to the Executive Committee for investigation, to report back to the members at the next meeting, seconded, and carried.

The Secretary read a letter from an attorney asking if the Society would consider it unethical for a practicing physician in Louisville to enter into an arrangement whereby he would use only the prescription pads of a given pharmacist. It was the opinion of the Judicial Council that they could not approve this practice, the Secretary was instructed to write a letter to the attorney to this effect.

The Secretary read a letter from the Blood Bank committee of San Antonio, Texas, who is studying the advisability of instituting a community blood bank, and requesting the opinion of the Society as to the relative merits of a Red Cross Blood Bank or a locally owned community blood bank.

Motion by Dr. Austin Bloch that the Society place itself on record as approving the Red Cross Blood Bank which has proved itself very satisfactory, seconded and carried.

Dr. B. W. Smock presented for the Society's consideration the matter of commercial exploitation of the medical profession by television and radio programs on which breakfast cereals, tobacco products, etc., are advertised as being endorsed by the medical profession. He recommended, but not in the form of a motion, that this problem be discussed and referred to its proper committee for investigation. He suggested that auxiliary members gather information by listening to these programs and make notes for the committee investigating this practice, which Dr. Smock considered a breach of the Kentucky Statute protecting doctors of medicine.

The President suggested that Dr. Sam Overstreet bring this matter to the attention of the auxiliary of the State Medical Association. The meeting adjourned at 9:30 p.m.

Austin Bloch, Secretary

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### MUHLENBERG

Meeting was called to order by the Vice-President, Dr. F. Wilson, following the resignation of Dr. Richardson as President. Dr. Wilson was confirmed as President, and Dr. R. E. Davis was elected Vice-President.

Minutes of the last meeting were read and approved.

Operating Room, Explosion hazards.

On motion of the Chairman of the Surgical Staff, it was agreed that the electro-cautery would not be used in the operating room during the use of Cyclopropane.

The Secretary transmitted the inspection report of the American College of Surgeons. This had been made available to the members in form of individual summaries, and the action taken on the various recommendations of the College is outlined in appropriate headings below.

The Medical Records Committee reported considerable difficulty in keeping abreast of

their volume of work. General quality of the records had improved over the months.

The report of the Inspector of the American College of Surgeons was considered in great detail. To secure compliance with the recommendations for improvement, a number of general policies were agreed upon. These included:

1. Submission by the Surgical Staff of an adequate policy for appraisal of reporting an investigation for infections.
  2. Submission (as above) of a summary of all fatal cases for review by the Medical Records Committee and/or Staff.
- 
3. Calling of Section Meeting by the Heads of Sections at least monthly, for the study of mortalities and other considerations of the action in each Section.
  4. Preparation by the Surgical Staff, of an adequate policy on consultation for submission and adoption by the Medical Staff.

On motion, the meeting was adjourned.

G. F. Brockman, Secretary

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### SCOTT

The Scott County Medical Society held its regular monthly meeting on Thursday, July 5, 1951, at the John Graves Ford Memorial Hospital with the following members present: W. S. Allphin, M. D.; L. F. Heath, M. D.; A. F. Smith, M. D.; H. G. Wells, M. D.; D. E. Clark, M. D.; E. C. Barlow, M. D.; and H. V. Johnson, M. D.

Minutes of the previous meeting were read and approved. Dr. Allphin, President of the Society, turned the meeting over to Dr. Wells, Chief of Staff of the Hospital, who then called a meeting of the Hospital Staff for a discussion of our needs.

H. V. Johnson, Secretary



## News Items

J. Gant Gaither, M. D., Hopkinsville, was given an honorary degree of Doctor of Science by the University of the South at Sewanee, Tennessee, early in June.

Abbott Cull, M. D., of Carrollton, has opened an office in Corinth, Kentucky. Dr. Cull is a graduate of the University of Louisville School of Medicine in 1950, and had his internship at St. Lawrence Hospital, Lansing, Michigan.

O. D. Sparks, M. D., London, was elected Commander of the Eleventh District of the Kentucky Department of the American Legion, during a recent district meeting.

W. R. Miner, M. D., and W. Vinson Pierce, M. D., Covington, have announced their intention to take in Robert S. Leake, M. D., as an associate in the practice of Urology. Dr. Leake is a graduate of the University of Cincinnati College of Medicine in 1945. He served his internship and residencies at the Cincinnati General Hospital, Cincinnati, Ohio, and at the Veterans Administration Center, Dayton, Ohio.

Hubert C. Jones, M. D., who has been associated with the Lexington Clinic, Lexington, has moved to Berea where he has opened an office. A graduate of the University of Louisville School of Medicine in 1943, Dr. Jones had his internship at St. Elizabeth Hospital, Covington, and residencies at Louisville General Hospital and St. Joseph Hospital in Lexington.

Joseph R. Griffitt, M. D., has located at Mt. Washington. A native of Iowa, Dr. Griffitt received his degree from the University of Louisville School of Medicine in 1950 and interned at St. Anthony's Hospital, Louisville.

W. W. Borsch, Jr., M. D., Louisville, has announced his association with John E. Ryan, M. D., a graduate of University of Louisville in 1950 who interned at the United States Naval Hospital, Great Lakes, Illinois.

Marion F. Beard, M. D., Louisville, has announced that Everett H. Sanneman, Jr., M. D., is now associated in practice with him. Dr. Sanneman comes from Illinois and is a graduate of the Washington University School of

Medicine in 1945. He interned in St. Louis City Hospital, served two years in the Army, and had his residencies at Nichols Veterans Administration Hospital and Louisville General Hospital.

R. J. Seebold, M. D., a graduate of the University of Louisville in 1939, has announced the opening of his office in Buechel. Dr. Seebold formerly practiced in Harlan County.

W. Burr Atkinson, M. D., who for the past five years has practiced in Lebanon, Kentucky, has announced that he will return to Campbellsville, where he will share professional quarters with W. W. Shepherd, M. D., of that city.

George L. Richardson, M. D., Beechmont, President of the Muhlenburg County Medical Society, has resigned that office and has moved to Adairville, Logan County, to continue his practice. Dr. Richardson is a graduate of the University of Louisville School of Medicine, 1945.

According to the Paducah Press, D. Y. Keith, M. D., and W. E. Sloan, M. D., of Paducah, have received a building permit to remodel a residence at 145 Broadway, Paducah, for a small hospital.

Eugene Tuess, M. D., has joined the medical staff of the State Tuberculosis Hospital at Glasgow. A native of Estonia, Dr. Tuess comes to Glasgow from Winchester.

I. A. Arnold, M. D., Louisville, has taken Mervin B. O'Neil, M. D., as an associate. After graduating from the University of Michigan School of Medicine in 1944, Dr. O'Neil, a native of Missouri, interned at Ohio State University Hospital, served in the Army, and took additional work at Norton Memorial Infirmary, Louisville, for a year ending June 30, 1951.

Marc James Reardon, M. D. who practices general and thoracic surgery, has moved his office from Cincinnati, Ohio, to Covington. A native of Cincinnati, Dr. Reardon graduated at the University of Cincinnati College of Medicine in 1942, and received his hospital training at University of Virginia and Duke University.

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RESEARCH IN THE  
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I. Wilson Gittleman, M. D., has opened his office in the Francis Building, Louisville, and will limit his practice to Cardiology and Peripheral Vascular Disease and Internal Medicine. He is a native of Louisville and graduated from the University of Louisville School of Medicine in 1945. He had his internship at Mt. Sinai Hospital, Cleveland, Ohio, and served several years at Veterans Hospitals in Lexington and Louisville.

O. D. Maxey, M. D., has located in Paducah, and will limit his practice to Urology. A graduate of Baylor University School of Medicine and a native of Oklahoma, he interned in Nashville General Hospital and had residencies at Methodist Hospital, Peoria, Illinois; New York Polyclinic Hospital; and Louisville General Hospital.

William H. Rosenblatt, M. D., Louisville, is now doing postgraduate work in Internal Medicine at the University of Pennsylvania.

H. B. McWhorter, M. D., Greenup, has accepted a commission in the U. S. Army Air Force. He is stationed with the 122nd Medical Group, Baer Field, Fort Wayne, Indiana.

Dr. Ewen Fraser, Edinburgh, Scotland, has been elected all time Health Officer of Campbell County. Dr. Fraser was graduated from the University of Edinburgh in 1928 and was formerly in charge of a tuberculosis sanitarium in Canada.

Socialized medicine in the British Isles was one of the prime reasons he left Scotland. Dr. Fraser will replace Dr. James O. Haizlip, Ft. Thomas, who has served as acting health officer for the past four years.

C. V. Hiestand, M. D., Campbellsville, was recently honored upon having completed fifty years of practice, by the Tri-County Medical and Dental Society at a dinner meeting in Campbellsville.

Thirty physicians and dentists and their wives from Taylor, Green and Adair Counties were present when Lyman S. Hall, M. D., Campbellsville, who presided, introduced the 80 year old veteran of medicine.

Dr. Leonard T. Davidson, professor of pediatrics at the University of Louisville Medical School, has been elected president of the Kentucky Society for The Advancement of

Pediatrics. He succeeds Dr. Harry S. Andrews.

Other officers elected at the group's second annual meeting were vice-president, Dr. William Maxson, Lexington, and secretary-treasurer, Dr. Cathryn Handelman, director of maternal and child health for the State Department of Health.

## BOOK REVIEWS

**ADMINISTRATIVE MEDICINE** by Haven Emerson A. M., M. D., Professor Emeritus of Public Health, DeLamar Institute of Public Health, College of Physicians and Surgeons, Columbia University. Thomas Nelson and Sons, Publishers. New York. Price: \$10:00.

The author is well known to Kentucky audiences as he has been guest speaker on several occasions before health groups and also made a survey of status of the Jefferson County and the City of Louisville Health Departments.

All forms of administrative medicine are discussed on his particular subject by nationally known authorities. The chapter devoted to the use of EGC vaccine is timely and interesting. The School Health Programs receive their share of attention.

This book should be a guide to all our health departments and used liberally in solving their many problems.

**PRACTICAL CLINICAL PSYCHIATRY—7th Edition** by Edward A. Strecker, Litt. D., LL.D., M. D., Professor of Psychiatry, School of Medicine, University of Pennsylvania; Franklin G. Ebaugh, M. D., Professor of Psychiatry, University of Colorado; School of Medicine and Director, Colorado Psychopathic Hospital; and Jack R. Ewalt, M. D., Professor of Neuro-Psychiatry and Administrator of Hospitals, University of Texas, Medical Branch, Galveston, Section on "Psychopathologic Problems of Childhood" by Leo Kanner, M. D., Associate Professor of Psychiatry, Johns Hopkins University School of Medicine. 35 Figures; 14 Tables; 506 Pages; June 13, 1951. The Blakiston Company, Publishers. Philadelphia 5, New York 22. Price: \$7.00.

This seventh edition of a standard text of psychiatrists has been brought completely up-to-date with modern psychiatric teaching and thought.

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patients, and need to keep abreast of modern developments.

The Armed Forces Classification of Mental Disorders as well as the American Psychiatric Association Classifications of Mental Disorders is included. There is a new section on Support Therapy which outlines effective methods of treating patients requiring treatment less extensive than orthodox analytic procedures.

New case histories are included throughout to illustrate the basic principles.

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**ANTIBIOTICS AND CHEMOTHERAPY, A Journal of Experimental and Clinical Studies on Antibiotics, Hormones, and Chemotherapeutics.** Henry Welch, Ph.D., Editor-in-Chief, Director Division of Antibiotics, Food and Drug Administration, Washington, D. C., Felix Martin Ibanez, M. D., International Editor, New York City, N. Y. Published 12 times the year, with annual cumulative subject and author index bound in number 12. Subscription rate: \$10 per year; \$22.50 for three years. Published by the Washington Institute of Medicine for M. D. Publications, Ind.

This Journal is published under a well known group of internationally recognized authorities. The ever increasing scope of the research and clinical developments in the fields of Antibiotics, Hormones and Chemotherapeutics has rather definitely indicated the need for a specialized publication wherein papers reporting the newer developments and applications might be promptly published.

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**SPATIAL VECTOR ELECTROCARDIOGRAPHY: CLINICAL ELECTROCARDIOGRAPHIC INTERPRETATION;** by Robert P. Grant, M. D., National Heart Institute, Bethesda, Maryland; and E. Harvey Estes, Jr., M. D., U. S. Naval Hospital, Bethesda, Maryland. Publishers: The Blakiston Company, Philadelphia 5, New York 22, Toronto 2. 1951. Price \$4.50.

The problem of reading and interpreting electrocardiographs is simplified for practitioners and students in this text by the use of vector methods. It is written in simple and non-technical terms for daily use by those who have had no special training in physics or mathematics.

It contains only those theoretical aspects absolutely indispensable for a clear understanding of the clinical application of ECG.

The use of vector methods gives simple, accurate and objective interpretations of normalities and abnormalities. When combined with the "pattern" and empirical methods, it makes the interpretation objective rather than intuitive. This book is not a textbook on electrocardiography. Many aspects of clinical electrocardiography are not discussed. Only the ventricular ECG is considered; that is, the QRS and T deflections. The author in writing this book recognized that the average physician not only has had little training in mathematics or physics, but frequently has a fairly deep aversion for these sciences. Accordingly, the material and the concepts have been presented in as simple and nontechnical terms as possible. Only the theoretical aspects which seemed absolutely indispensable for clear understanding of the clinical applications have been included. Such simplification of an intrinsically complex subject necessarily leads to inaccuracies, generalizations, and dogmatisms. The reader is referred to the bibliography for more accurate and comprehensive discussions of these aspects of the subject. Most cardiologists are steeped in medical lore and will enjoy the quotation of the famous Roman philosopher Lucretius in the introduction.

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**HANDBOOK ON OBSTETRICS AND GYNECOLOGY** by Leo Doyle, M. S., M. D. First Edition. Illustrations by Ralph Sweet. University Medical Publishers, Post Office Box 761, Palo Alto, California. Price: \$2.00.

The purpose of this handbook is to present in the most concise form possible the essential features of obstetrics and diagnostic gynecology. It is neither a textbook or a reference book. The information is outlined so that it may be easily available and referred to without difficulty. Controversial matters have been avoided wherever possible, and certain instances in which the physiology involved is not clearly understood, alternative hypotheses have been presented, and specific treatment has been indicated by the probable change in the normal physiology. Description of surgical technics have been avoided because it is impossible to present them adequately in a handbook.

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NO. 9

OFFICERS OF KENTUCKY STATE MEDICAL ASSOCIATION



SAM A. OVERSTREET, M. D.

President

LIBRARY OF THE  
COLLEGE OF PHYSICIANS  
OF KENTUCKY



## W. CLARK BAILEY

### President-Elect

William Clark Bailey, M. D., who will be the Association's first president as it starts the second hundred years, was born in Harlan, Kentucky, January 18, 1900, the son of Granville Pearl Bailey, M. D., one of the first physicians to practice in Harlan County.

Graduating from Harlan High School in 1917, Dr. Bailey took one year at Cumberland College; then entered Georgetown College in the fall of 1918. Before receiving his B. S. Degree from that institution in 1922, he took part in all sports and was active in other forms of campus life. In 1922 he entered the University of Louisville School of Medicine.

For Dr. Bailey 1926 was a big year. He received his M. D. Degree and he married Agnes Asher. His bride lived at Pineville, some 35 miles down the beautiful Cumberland River from Harlan. They have one son, Clark, Jr., who is currently serving with the United States Navy in Japan.

Dr. Bailey interned at the Tuberculosis Sanatorium in Louisville, Children's Free and Louisville City Hospitals. His father died and he returned to Harlan in 1927, to take over his father's office, where he has practiced since. A past president of the Harlan Kiwanis Club, Dr. Bailey has served on the City Board of Education for the past 18 years, and is a member of the Board of Trustees of Georgetown College.

In addition to being a member of the County, State and American Medical Associations, our 1951-52 president belongs to the Southern Medical Association and is a founder member of the World Medical Association. He is a past president of his County Society, has held numerous committee appointments in both local and state organizations, and has presented four papers before the Annual Meeting.

In 1944 Dr. Bailey was elected by the House of Delegates to represent Kentucky as a delegate to the American Medical Association. He served in this Association for six consecutive years before his resignation at the close of the 1950 Meeting, when he was elevated to the office of President-Elect of K.S.M.A.

Delegates to the American Medical Association represent the best organizational talent of the constituent state societies, and being an A.M.A. delegate is a coveted

office. Top medical leadership in the A.M.A. House of Delegates is commonplace. The outstanding work of this practitioner, from high in the mountains of southeastern Kentucky, soon won him the respect of his fellow delegates. He was given more and more responsibility, and when he resigned he was chairman of one of the important Reference Committees of that body.

When the House of Delegates at the 1950 Annual Meeting of our Association considered the matter of a successor for the new president, Sam A. Overstreet, M. D., many worthy and capable leaders were mentioned, each with a loyal and devoted following. When the votes were counted, however, it became apparent that Harlan County, rich in coal, and medical tradition, had given birth to its third K.S.M.A. President-Elect by a comfortable margin.

The House of Delegates may take pride in the judgment that has been exercised in selecting our Chief Executive. Because of his experience, energy, astuteness, integrity and personal warmth, the House feels it has chosen an excellent president to direct the affairs of our Association in the precarious days that are ahead for medicine.

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### Vice-Presidents

J. PEPPER GLENN, M. D.

Russellville



Dr. Glenn was born in Kirkmansville, Todd County, on January 16, 1907. He received his pre-medical education at Kentucky Wesleyan and was graduated from the University of Louisville School of Medicine in 1932. He has practiced in Russellville since 1933 except for the period from 1942 to 1945 when he was in the Navy. Dr. Glenn is a member of the Logan County Medical Society and of Kentucky State Medical Association, and the American Medical Association. He is a Fellow of the American Medical Association, a member of the Southeastern Surgical Congress, and is a Fellow of the American College of Surgeons.



*Clark Bailey*

PRESIDENT KENTUCKY STATE MEDICAL ASSOCIATION 1951





**M. J. HENRY, M. D.**

**Louisville**



Dr. Henry was born in Louisville on June 18, 1899. He attended St. Meinrad College, St. Meinrad, Indiana, and was graduated from the University of Louisville School of Medicine in 1912, and interned at St. Joseph Infirmary in Louisville. Following three years of postgraduate work at the Mayo Clinic, Rochester, Minnesota, he returned to Louisville in 1916 and became associated with the late Dr. Irvin Abel as a general surgeon. Dr. Henry is a member of the Jefferson County Medical Society and of Kentucky State Medical Association and is a Fellow of the American Medical Association. He is a member of the Southern Surgical Association and is a Fellow and a member of the Board of Governors of the American College of Surgeons. He is a Diplomate of the American Board of Surgery. Dr. Henry has been Chairman of the Louisville-Jefferson County Board of Health. He is a firm believer in a free profession and has been a staunch defender against governmental intervention in the practice of medicine.

**CHARLES B. STACY, M. D.**

**Pineville**



Dr. Stacy was born in Cannell City, Kentucky, on January 18, 1901. He received his pre-medical education at Berea College and was graduated from the University of Louisville School of Medicine in 1926. He interned at the U. S. Public Health Service Marine Hospital in New Orleans, and has practiced surgery in Pineville since 1927. Dr. Stacy has been a loyal supporter of organized medicine in his County and State Association and is a Fellow of the American Medical Association. He is a Diplomate of the American Board of Surgery and is a member of the American Association of Industrial Physicians and Surgeons. He delivered the Oration in Medicine at the Annual Meeting in 1943.

**Secretary-Editor**

**BRUCE UNDERWOOD, M. D.**

**Louisville**



Dr. Underwood has completed three years of service as Secretary-Editor. It is his ambition to conduct the affairs of the Association in the manner desired by the membership. Through the medium of the Secretary's Letter and the pages of the Journal he attempts to keep all members informed of the activities of the Association and of the problems that confront us. He invites your suggestions and your constructive criticisms.

**Treasurer**

**WOODFORD B. TROUTMAN, M. D.**

**Louisville**



Dr. Troutman has served our Association as Treasurer for five years, having been first elected in 1946. Although he is a busy cardiologist he is always ready to give as much of his time as is required to carry out the duties of his office in an efficient manner. He is keenly interested in the financial affairs of the Association.

**Speaker**

**HUGH L. HOUSTON, M. D.**

**Murray**



One of the recommendations made by the Committee on Constitution and By-Laws was that the offices of Speaker and Vice-Speaker be created. The House of Delegates accepted the recommendation and Dr. Hugh L. Houston was elected as Speaker of the House of Delegates. It is his duty to preside over the meetings of the House of Delegates, thereby relieving the president from this arduous task and making it possible for him to give his attention to other important matters pertaining to the An-



nual Meeting.

It is necessary for the Speaker to be a good parliamentarian, to have an exact knowledge of our Constitution and By-Laws, and to be familiar with the activities and organizational structure of the Association. The selection of Dr. Houston was a happy choice for the position. As a past president, councilor, and active worker in the Association, he has gained the experience to eminently qualify him for this office.

### Vice-Speaker

**CHARLES A. VANCE, M. D.**

**Lexington**



Since it is the duty of the Vice-Speaker to preside over the deliberations of the House of Delegates in the absence of the Speaker, it is highly important for him to possess all of the qualifications mentioned above.

It would indeed be difficult to find a member of the Association better qualified as a presiding officer of the House than Dr. Charles A. Vance. Dr. Vance has gained his intimate knowledge of the affairs of the Association through many years of loyal, faithful and devoted service. He has served as president, vice-president, councilor, chairman of the council, and has headed many important committees of the Association.

### Delegates To A.M.A.

**J. DUFFY HANCOCK, M. D.**

**Louisville**



In electing Dr. J. Duffy Hancock, as a delegate to A.M.A., the 1950 House of Delegates selected a man for the position who had already proven his capability for the office. Dr. Hancock was serving our Association in the same capacity when he entered the U. S. Army in 1942.

Dr. Hancock has practiced surgery in

Louisville since 1921, following graduation from the University of Louisville School of Medicine and internship at New York Postgraduate Hospital. He delivered the Oration in Surgery at the 1947 Annual Meeting. Dr. Hancock is a Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons. He is Associate Clinical Professor of Surgery at the University of Louisville School of Medicine. Dr. Hancock is President of the Kentucky Division of the American Cancer Society and has made a great contribution toward the development of the state-wide cancer control program.

**J. B. LUKINS, M. D.**

**Louisville**



Dr. Lukins has served as a delegate to the American Medical Association for ten years. Having served as Councilor, Chairman of the Council, and President, he is capable of truly representing our Association at the National Convention.

Although Dr. Lukins has served the Association in many capacities, perhaps his most valuable contribution has been as Chairman of the Medico-Legal Committee. His record of accomplishment in this field of activity has rarely been equalled in this country. He has won many friends through his skillful handling of Medico-Legal matters.

Dr. Lukins' term as delegate expires in 1951.

**BRUCE UNDERWOOD, M. D.**

**Louisville**

Dr. Underwood was elected as a delegate last year by the Council when the membership of the State Association passed the 2,000 mark, entitling us to 3 delegates. His election for the remainder of the term was confirmed by the House of Delegates. He has represented our Association at two meetings of the House of Delegates of A.M.A. His term expires this year.

## President's Luncheon, Oct. 4, Will Honor Distinguished Guests

The President's Luncheon honoring our distinguished visitors, a new feature of our Annual Meeting, will be held in the Roof Garden of the Brown Hotel at 12:00 o'clock, Wednesday, October 3.



Dr. Cline

John W. Cline, M. D., San Francisco, President of the A. M. A., will be the featured speaker, Sam A. Overstreet, M. D., Louisville, Chairman of the Program Committee, announced. Dr. Cline will discuss "The Problem Confronting Medicine in the

Immediate Future."

The distinguished essayist will be seated at the Speaker's Table and will be introduced. Guests from neighboring associations will be recognized.

Dr. Overstreet said, "I wish to make it quite clear that ample time will be allowed on our program for this feature." Tickets may be purchased at Registration Desk and Education Sub-Committee Booth.

## Century of Medical Developments to be Depicted in Exhibits

Among the Centennial features requiring the most exacting and difficult preparations to arrange are the Historical Exhibits, which are being developed by William R. McCormack, Chairman of the Centennial Sub-Committee on Historical Exhibits.

These exhibits, which you will want to see, will be located in the room immediately to the right, just inside the main entrance at the Columbia Auditorium. Each exhibit will have uniform backing and props.

The K.S.M.A. exhibit, depicting 100 years of medical progress, is being set up by the Woman's Auxiliary to the Association Committee: composed of Mrs. Malcolm Barnes, Louisville, Chairman, Mrs. Irving Gail, Lexington, and Mrs. Walker Owens, Mt. Vernon.

Allied professions having historical exhibits are: the Kentucky State Dental Association, Kentucky State Department of

Health, Kentucky State Hospital Association, Kentucky Pharmaceutical Association, and the Kentucky State Association of Registered Nurses. The Association is honored to have these organizations share in its celebration, said Dr. McCormack.

The K. S. M. A. exhibit will feature 12 historical pictures, painted especially for this exhibit, together with a display of medical instruments and equipment, carefully selected to show the successive stages of their development, Mrs. Barnes stated.

## Centennial Banquet, Oct. 4, to End Three Day Celebration

The Centennial Banquet, the final, crowning event of our 100th Birthday Celebration, will be held in the Crystal Ballroom of the Brown Hotel, Thursday evening, October 4, and will be filled with attractive features.

"Golden Spikes" is the subject of the Presidential Address that Sam A. Overstreet, M. D., will present. You will find what Dr. Overstreet has to say absorbing, timely and profitable. It is the product of a year's exhaustive research and thought.

Other high points of the program include recognition of the University of Louisville Medical School reunion classes of '01, '11, '21, '31 and '41, inaugural ceremonies and dancing. Purchase your tickets early at Registration Desk or Education Sub-Committee Booth.

## Intermission to View the Exhibits Planned for Each Session

Being conscious of the importance of the exhibits to the Centennial Meeting, the Association officials planning the arrangements have provided for a 30 minute intermission during each half-day scientific session.

At this time those in attendance will have an opportunity to visit the 64 technical and 25 scientific exhibits in the exhibit hall and the 6 historical exhibits off the main entrance.

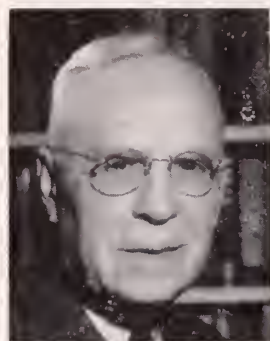
The exhibits are a substantial contribution to the Centennial Celebration, and members are warmly urged to visit each one. The Scientific and Technical Exhibits Hall will not open after noon on Thursday.



## Dr. Moorman, Historical Program Feature Public Meeting

The General Public Meeting of the Centennial Session, to be held in Columbia Auditorium, Tuesday evening, October 2, will have a program of unusual interest.

The program will open with a distinctive historical feature, built around the life and deeds of Ephraim McDowell, whom the Annual Meeting commemorates. A vast amount of research and preparation have gone into this presentation.



"Kentucky, the Progenitor of Pioneer Doctors" will be the title of the address by Lewis J. Moorman, M. D., Oklahoma City, principal speaker of the evening. A native of Leitchfield and a graduate of the University of Louisville

School of Medicine, Dr. Moorman is Secretary-Treasurer of the Oklahoma State Medical Association and Editor of the Journal of the Oklahoma State Association. The author of numerous medical textbooks and articles, his work "Pioneer Doctor" was published this year. He was president of the Southern Medical Association, and is a former Dean of the Oklahoma School of Medicine.

The recipients of the Association's three Annual awards will be announced at the meeting. Keen interest in the awards was manifested this year, and there were numerous nominations for each honor.

The Committee on Arrangements urges you to attend this excellent program and to bring your lay friends with you.

## Five Class Reunions to be Held During Centennial Session

Indications are that the reunions of classes '01, '11, '21, '31 and '41 of the University of Louisville School of Medicine, to be celebrated in connection with the Centennial Meeting, will be unusually well attended.

Special tables will be reserved at the Centennial Banquet, to be held in the Crystal Ballroom at the Brown Hotel, for the members of these classes. Each class is to be recognized at the dinner.

The men who have been selected as chairmen of the five reunions are:

Class of 1901—E. S. Allen, M. D., Francis Bldg., Louisville

Class of 1911—G. C. Harrod, M. D., Columbus, Indiana

Class of 1921—D. P. Hall, M. D., Heyburn Bldg., Louisville

Class of 1931—William K. Keller, M. D., General Hospital, Louisville

Class of 1941—Sam Clark, M. D., Heyburn Bldg., Louisville

The Association is grateful to the University of Louisville and to Alumni Relations Secretary, Les Shively, for making this feature of the Centennial possible.

## THE COUNCIL

Upon a recommendation of the committee which was appointed at the Owensboro meeting in 1949 to study the problem, the House of Delegates voted to increase the number of Councilor Districts from eleven to fifteen. This action, plus expired terms, resulted in the election of five new councilors. These councilors who have now served a full year are: Delmas M. Clardy, M. D., Hopkinsville, Third District; B. B. Baughman, M. D., Frankfort, Seventh District; J. R. Cummings, M. D., Flemingsburg, Ninth District; Hugh Mahaffey, M. D., Richmond, Eleventh District; and Clyde C. Sparks, M. D., Ashland, Thirteenth District.

It is the feeling of the group that attends the Council Meetings that increasing the number of councilors has had the effect of increasing the democracy of the body. Since the districts are smaller in area, each councilor is closer to the members that he represents and is more familiar with their thinking on the various important matters that come before the group. In addition to the councilors, the president, president-elect, immediate past-president, speaker, vice-speaker, secretary, treasurer, and members of the headquarters staff attend the meetings. Discussion is lively and decisions are reached only after due consideration has been given to the matters at hand.

Councilors contribute generously of their time and carry a heavy responsibility in setting policies and guiding the affairs of the Association between the meetings of the House of Delegates. They sincerely and honestly serve the profession and deserve the appreciation and cooperation of every member of the Association.

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# COUNCILORS

—:

First District



J. VERNON PACE  
Paducah

Second District



R. HAYNES BARR  
Owensboro

Third District



DELMAS M. CLARDY  
Hopkinsville

Fourth District



J. I. GREENWELL  
New Haven

Fifth District



R. R. SLUCHER  
Buechel

Sixth District



C. C. HOWARD, Chm.  
Glasgow

Seventh District



B. B. BAUGHMAN  
Frankfort

Eighth District



EDW. B. MERSCH  
Covington

Ninth District



J. R. CUMMINGS  
Flemingsburg

Tenth District



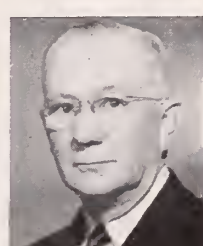
J. F. VANMETER  
Lexington

Eleventh District



HUGH MAHAFFEY  
Richmond

Twelfth District



CARL NORFLEET  
Somerset

Thirteenth District



CLYDE C. SPARKS  
Ashland

Fourteenth District



PAUL B. HALL  
Paintsville

Fifteenth District



CHAS. D. CAWOOD  
Middlesboro



# *Program*

## THE EPHRAIM McDOWELL MEMORIAL MEETING

Celebrating the One-Hundredth Anniversary

of the

KENTUCKY STATE MEDICAL ASSOCIATION

OCTOBER 1, 2, 3, 4, 1951

LOUISVILLE

### MONDAY, OCTOBER 1

3:00 P.M.	Council Meeting .....	Louis XVI Room, Brown Hotel
5:00 P.M.	Council Dinner .....	Louis XVI Room, Brown Hotel
6:00 P.M.	Registration of House of Delegates .....	Columbia Auditorium
7:00 P.M.	First meeting of House of Delegates .....	Columbia Auditorium

### TUESDAY, OCTOBER 2

8:00 A.M.	Registration .....	Columbia Auditorium
9:00 A.M.	Opening of the General Session* .....	Columbia Auditorium
9:15 A.M.	First Scientific Session .....	Columbia Auditorium
2:00 P.M.	Second Scientific Session .....	Columbia Auditorium
2:00 P.M.	Reference Committee Meetings .....	Columbia Auditorium
8:15 P.M.	General Public Meeting .....	Columbia Auditorium

### WEDNESDAY, OCTOBER 3

9:00 A.M.	Third Scientific Session .....	Columbia Auditorium
12:30 A.M.	President's Luncheon for Distinguished Guests .....	Roof Garden, Brown Hotel
2:00 P.M.	Fourth Scientific Session .....	Columbia Auditorium
5:00 P.M.	Council Dinner .....	Louis XVI Room, Brown Hotel
6:00 P.M.	Registration, House of Delegates .....	Columbia Auditorium
7:00 P.M.	Second Meeting, House of Delegates .....	Columbia Auditorium

### THURSDAY, OCTOBER 4

9:00 A.M.	Fifth Scientific Session .....	Columbia Auditorium
12:15 P.M.	Council Luncheon .....	Louis XVI Room, Brown Hotel
2:00 P.M.	Sixth Scientific Session .....	Columbia Auditorium
7:30 P.M.	The Centennial Banquet .....	Crystal Ballroom, Brown Hotel

\*A 30-Minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting the Historical, Scientific and Technical Exhibits.

# Scientific Program

## TUESDAY MORNING

October 2

### 9:00 OPENING OF CONVENTION

Invocation: Dr. Homer W. Carpenter

Welcome: Lytle Atherton, M. D.

Response: C. C. Howard, M. D.

### FIRST SCIENTIFIC SESSION

Sam A. Overstreet, M. D.

Presiding

#### 9:30 "Doctors are Citizens Too," R. B. Chrisman, Jr., M. D., Miami, Florida.

Dr. Chrisman was born in Hazel, Kentucky, in 1911. He is a graduate of Murray State Teachers College, Murray, Kentucky, and of the University of Tennessee College of Medicine where he received his M. D. in 1938. During World War II he was Chief of Surgery of the Station Hospital, Camp Forrest, Tennessee, and was Commanding Officer of the 220th General Hospital in France. He is Chairman of the Florida Committee for Better Government, an organization comprised of physicians which functions apart from organized medicine and seeks to stimulate physicians to become more actively interested in local, state and national government affairs.

#### 10:00 "Unilateral Upper Extremity Pain," W. Gayle Crutchfield, M. D., Charlottesville, Virginia

Dr. Crutchfield was born in Henry County, Kentucky, in 1900 and received his A. B. Degree from the University of Kentucky in 1923. He was graduated from Johns Hopkins University School of Medicine in 1927. Following

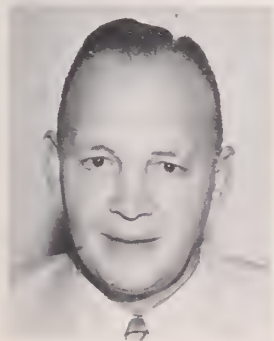
four years of internship and residency, Dr. Crutchfield was appointed as Assistant Professor of Urological Surgery in the medical college of Virginia. Since 1941 he has been Professor of Urological Surgery in the same institution. He is a Consultant to the U. S. Naval Medical Center at Bethesda, Maryland, and to the Veterans Administration Hospital at Roanoke, Virginia, and is a member of many professional associations.

#### 11:00 "Some Physiological Considerations in the Treatment of Patients with Congestive Heart Failure," Drew Luten, M. D., St. Louis, Missouri.

Dr. Luten was born in Fulton County, Kentucky, in 1881, and received his A. B. degree from the University of Kentucky in 1901. He is a graduate of Johns Hopkins University School of Medicine, receiving his M. D. in 1911. Following internship he was a Resident Physician in Barnes Hospital, St. Louis, from 1914 to 1917. Dr. Luten is Associate Professor of Clinical Medicine, Emeritus, Washington University, St. Louis. He is the author of "The Clinical Use of Digitalis" which was printed by Charles C. Thomas in 1936 and of "The Clinical Course of Coronary Disease."

#### 11:30 "Oration in Medicine," Carl Fortune, M. D., Lexington, Kentucky.

Dr. Fortune was born in 1900 in Chagrin Falls, Ohio, but moved to Lexington, Kentucky, in 1912. He was graduated from Transylvania College in 1922 and received his M. D. from University of Michigan Medical School in 1926 and took postgraduate training at the University of Michigan from 1926 to 1931 where he was Instructor in



Dr. Chrisman



Dr. Crutchfield



Dr. Luten



Dr. Fortune



Pathology, Resident in Internal Medicine and Instructor in Internal Medicine. He entered private practice in Lexington in 1931. He served in the Army from 1942 to 1946 and was Chief of Medical Service of the 43rd Station Hospital and was Chief of Medical Service of the 191st General Hospital. He is a past president of the Fayette County Medical Society and of the medical staff of the Good Samaritan Hospital in Lexington, and is a Diplomat of the American Board of Internal Medicine. He is Attending Physician and Associate Chief of Internal Medicine at St. Joseph's Hospital; Attending Physician at Good Samaritan Hospital and is Consultant to Cardinal Hill Convalescent Hospital for Crippled Children. He is a Consultant in Internal Medicine at the U. S. Veterans Hospital, Lexington, and is a member of the Medical Advisory Boards of Julius Marks Sanatorium and of the Frontier Nursing Service.

## TUESDAY AFTERNOON

### SECOND SCIENTIFIC SESSION

Clark Bailey, M. D.

Presiding

- 2:00 "The Use of Excision of the Head in the Treatment of Fracture of the Neck of the Femur," Otho C. Hudson, M. D., Hempstead, Long Island, New York.

Dr. Hudson was born in Louisville, Kentucky, and is a graduate of the University of Louisville School of Medicine. His appointments include Chief of the Department of Surgery and Chief of the Orthopedic Department of Nassau Hospital, Mineola; Chief of the Orthopedic Department of Meadowbrook Hospital of Hempstead and Manhasset Medical Center, Manhasset. He is Consultant in Orthopedic

Surgery, North Country Communities Hospital, Glen Cove; Nassau County Tuberculosis Sanatorium, Farmingdale; Huntington Hospital, Huntington; South Side Hospital, Bay Shore, all of which are in New York.

- 2:30 "Recent Observations on Frostbite," Leonard Heaton, Major General, M. C., U. S. Army, Letterman General Hospital, San Francisco.

General Heaton is a native Virginian. He was born in Parkersburg on November 18, 1902. He took his pre-medical training at Dennison University and received his M. D. Degree from the University of Louisville School of Medicine in 1926. At the time of the Pearl Harbor attack, General Heaton was Chief of the Surgical Service of Rupp General Hospital, and for his excellent work during that emergency was awarded the Legion of Merit.

From 1945 to 1950 General Heaton was Chief of Surgical Service and Director of Professional Services of Letterman General Hospital. At present he is in command of Letterman Army Hospital.

- 3:30 "Infant Mortality as Related to the Three Leading Causes of Death," Fred P. Helm, M. D., Austin Texas.

Doctor Helm received his pre-medical education at Ohio University and was graduated from the University of Louisville School of Medicine in 1923. He interned at the Louisville General Hospital and at University Hospital in Oklahoma City. He received a degree of Master of Public Health from the University of Michigan in 1942. Doctor Helm is a Diplomat of the American Board of Preventive Medicine and Public Health. He has served as State Health Commissioner of Kansas and at present is Field Consultant and Senior Pediatrician of the Maternal and Child



Dr. Hudson



Maj. Gen. Heaton



Dr. Helm



Dr. Wilson

Health Division, Texas State Department of Health.

**4:00 "Coeliac Disease," William H. Wilson, M. D., New Haven, Connecticut.**

Dr. Wilson was born in Sturgis, Kentucky, in 1898 and is a graduate of the University of Kentucky. He received his M. D. degree from the Johns Hopkins University School of Medicine in 1925. He has practiced pediatrics in New Haven, Connecticut, since 1930 except from 1942 to 1945 when he was in the U. S. Navy from which he was discharged with the rank of Commander. He is now Associate Clinical Professor of Pediatrics at Yale University Medical School and Attending Pediatrician at Grace-New Haven Community Hospital and Hospital of St. Raphael, New Haven.

**WEDNESDAY MORNING**

**October 3**

**THIRD SCIENTIFIC SESSION**

**John P. Glenn, M. D.**

**Presiding**

**9:00 "Why Anemia?," Hugh Jeter, M. D., Oklahoma City, Oklahoma.**

Dr. Jeter is a native of Kansas and received his A. B. degree from the University of Kansas. He is a graduate of the University of Louisville School of Medicine and received postgraduate training in pathology at Aberdeen University, Aberdeen, Scotland. He is Consulting Professor of Pathology, University of Oklahoma Medical School and is Pathologist and Internist, St. Anthony Hospital, Oklahoma City. His private practice is limited to internal medicine and clinical pathology.

**9:30 "Human Injury from Atomic Explosion," Elbert DeCoursey, Brig. General, M. C.,**

**U. S. Army, Washington, D. C.**

General DeCoursey was born in Ludlow, Kentucky, in 1902, and is a graduate of the University of Kentucky and of Johns Hopkins University School of Medicine. General DeCoursey is a Pathologist who has served in many capacities in the Army including Assistant Curator of the Army Medical Museum; Commanding Officer of the 9th Army Area Laboratory; Laboratory Consultant, Pacific Ocean Theater; Member of the Joint Committee for Study of Effects of the Atomic Bomb in Japan and Director of the Army Group in Nagasaki. He was a member of the Naval Medical Research Section and Radiologic Safety Section, Operation Crossroads, Bikini, and was Commandant of the Army Medical Research and Graduate School. Since 1950 he has been Director of the Armed Forces Institute of Pathology. He is the author of "Atlas of Ophthalmic Pathology," "Pathology of Atomic Bomb Casualties" and of "Radiological Defense."

**10:30 "Not in the Thing Itself," Harry Beckman, M. D., Milwaukee, Wisconsin.**

Dr. Beckman was born in Louisville, Kentucky, and is a graduate of the University of Louisville School of Medicine. He took postgraduate training in the University of Vienna which was followed by military service in World War I. He is at present Director of the Department of Pharmacology of Marquette University School of Medicine, Milwaukee, Wisconsin.

**11:00 "Oration in Surgery," Charles Maguire, M. D., Louisville, Kentucky.**

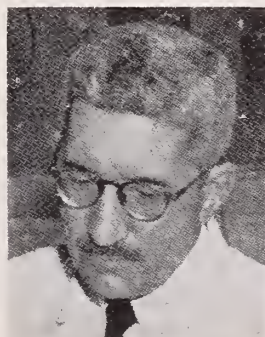
Dr. Maguire was born in Jacksonville, Florida, on November 8, 1910. He attended Cumberland College and is a graduate of the University of Kentucky and of the University of Louis-



**Dr. Jeter**



**Brig. Gen. DeCoursey**



**Dr. Beckman**



**Dr. Maguire**



ville School of Medicine from which he received his degree of Doctor of Medicine in 1936. He interned at Louisville City Hospital and has practiced surgery in Louisville since that date. Dr. Maguire is a member of his County and State Associations and is a Fellow of the American Medical Association and of the American College of Surgeons. He is also a member of the Southeastern Surgical Congress, the American Association for the Surgery of Trauma, and is Associate Professor of Surgery at the University of Louisville School of Medicine.

### WEDNESDAY AFTERNOON FOURTH SCIENTIFIC SESSION

M. J. Henry, M. D.

Presiding

**2:00 "Hypogonadism and Infertility in the Male," Henry Turner, M. D., Oklahoma City, Oklahoma.**

Dr. Turner was born in Harrisburg, Illinois, and is a graduate of the University of Louisville School of Medicine, class of 1921, and is a former resident of the Louisville General Hospital. He received postgraduate training at the University of Vienna and at Queens Square, London. He is at present Clinical Professor of Medicine, Oklahoma University School of Medicine; Chairman of General Research Advisory Board of Oklahoma Medical Research Foundation; Consulting Endocrinologist to the University Hospitals and is head of the Endocrine Clinic in the Out-Patient Department. Dr. Turner is the author of chapters on endocrine disorders in several books and of a monograph on "The Clinical Use of Male Sex Hormone." He has contributed some 30 articles on endocrinology to medical journals.

**2:30 "Acute Surgical Abdomen," Henry W. Cave, M. D., New York, New York.**

Dr. Cave was born in Paducah, Kentucky, in 1887, and was graduated from Centre College in 1909 and from Johns Hopkins University School of Medicine in 1913, following which he was on the Surgical Staff of Johns Hopkins Hospital. He took postgraduate work in Germany and spent two and one-half years at Roosevelt Hospital. He is now Clinical Professor of Surgery at Columbia University; Chief of the First Surgical Division of Roosevelt Hospital and is president of the American College of Surgeons. He is an Honorary Member of the Royal Society of Medicine, London.

**3:30 "The Diagnosis and Treatment of Aneurysms and Arterio Venous Fistulas," Daniel C. Elkin, M. D., Emory University, Georgia.**

Dr. Elkin was born in Louisville, Kentucky, in 1893. He received his A. B. degree from Yale University in 1916 and his M. D. from Emory University in 1920. He has been the Whitehead Professor of Surgery at Emory University since 1930, and Surgeon-in-Chief of Emory University Hospital since 1939. In the Army he was Chief of Surgical Services of Ashford General Hospital from 1942 to 1946 and was discharged with the rank of Brigadier General. He was awarded Matas Medal for Vascular Surgery, Tulane University, 1940, and the Legion of Merit in 1945.

**4:00 "Injuries to the Ankle," Robert P. Kelly, M. D., Emory University, Georgia.**

Dr. Kelly, a native of Virginia, was graduated from the University of Pennsylvania School of Medicine in 1937. Following an internship in Philadelphia, he came to Louisville in 1939 where he was Orthopedic Resident at



Dr. Turner



Dr. Cave



Dr. Elkin



Dr. Kelly

the Kosair Crippled Children's Hospital, and the following year was Resident in Orthopedics and Fractures in Louisville City Hospital. At present Dr. Kelly is Associate Professor of Surgery and Chairman, Section on Orthopedics, at the Emory University School of Medicine. He is also Orthopedic Consultant to the Surgeon General, U. S. Army, and to several Georgia hospitals. He is chief of Orthopedic Service at Emory University Hospital.

## THURSDAY MORNING

October 4

### FIFTH SCIENTIFIC SESSION

Charles B. Stacy, M. D.

Presiding

- 9:00 "Observation on the Occurrence of Tropical Diseases in New Guinea, the Philippines, Japan and Korea during and following World War II," Dwight M. Kuhns, M. D., Colonel, U. S. Army, Washington, D. C.

Dr. Kuhns is a native of Missouri, but was graduated from the University of Louisville School of Medicine in 1929. As 7th Corps Area Laboratory Officer and as a Member and Director of the Research Board for Control of Spinal Meningitis, he developed a meningococcus soluble toxin for skin testing and immunizing C.C.C. enrollees. He has served as Pathologist and Bacteriologist in the Board of Health Laboratory, Gorgas General Hospital, Canal Zone; Commanding Officer of the 4th Service Command Laboratory, Atlanta; Laboratory Consultant to all troops in the Southwest Pacific and commanded one of the Medical Research Laboratories serving under General MacArthur in New Guinea and the Philippines. He was Commander of the 4th Army Area Medical Laboratory, Fort

Sam Houston. At the present time he is Chief, Laboratory Service, Walter Reed Army Hospital, Washington.

- 9:45 "Encouragements in Cancer Surgery," Fred W. Rankin, M. D., Lexington.

Dr. Rankin, a native of North Carolina, received his M. D. from University of Maryland in 1909. A past president of the A.M.A. and one of the 13 original members of the American Board of Surgery, he was Chief of the Surgical Section, Mayo Clinic, from 1926 to 1933, the year he entered private practice in Lexington. In World War II he was attached to the Surgeon General's Office as Chief Consulting Surgeon to U. S. Armies with the rank of Brigadier General.

- 11:00 "Ulcer and Cancer of the Stomach," Arthur W. Allen, M. D., Boston, Massachusetts.

Dr. Allen was born in Lincoln County, Kentucky, in 1887. He was graduated from Georgetown College in 1909 and from Johns Hopkins University School of Medicine in 1913. He was for many years Chief of East Surgical Service, Massachusetts General Hospital, and a Lecturer in Surgery at the Harvard Medical School. He is a past president of the American College of Surgeons and of his state association. He is an Honorary Fellow of the Royal College of Surgeons of England and Edinburgh and is Consultant in Surgery, Massachusetts General Hospital and is Chairman of the Board of Regents of the American College of Surgeons.

- 11:30 "Cortisone and ACTH in the Treatment of Chronic Arthritis," Russell L. Cecil, M. D., New York, New York.

Dr. Cecil was born in Nicholasville, Kentucky. He was graduated from Princeton University in 1902 and from the Medical College of Virginia in 1906.



Col. Kuhns



Dr. Rankin



Dr. Allen



Dr. Cecil



Postgraduate training was received at Johns Hopkins Hospital and in Vienna and Berlin. Dr. Cecil performed research work in pneumonia, his interest having been alerted during World War I while he was associated with the Army Medical School. Dr. Cecil is also well-known for his research on rheumatoid arthritis. For several years he was an Instructor of Clinical Medicine at Columbia University and Cornell Medical School and has been Professor of Clinical Medicine at Cornell since 1933. He is the author of Cecil's "Textbook of Medicine" which is a required text in practically all medical schools in the United States and has been translated into Spanish, Portuguese and Chinese. He is also an amateur painter.

#### THURSDAY AFTERNOON

#### SIXTH SCIENTIFIC SESSION

**Sam A. Overstreet, M. D.**

**Presiding**

**2:00 "Relapsing Pancreatitis," Earl E. Gambill, M. D., Mayo Clinic, Rochester, Minnesota.**

Dr. Gambill was born in Blaine, Kentucky, and received his A. B. degree from Berea College in 1930. He was graduated from the University of Pennsylvania Medical School in 1935. He was associated with the Kentucky State Department of Health from 1935 to 1938 as Director of the Rural Public School Health Program. He interned in Passavant Memorial Hospital, Chicago, and was a Fellow in Medicine from 1939 to 1942 of the Mayo Foundation, and since 1944 he has been Consultant in Medicine at the Mayo Clinic and is Assistant Professor of Medicine, Graduate School of Medicine, Mayo Foundation, University of Minnesota.



**Dr. Gambill**



**Dr. Ball**



**Dr. Juers**

**2:30 "The Present Status of Cardiac Surgery," Julian Johnson, M. D., Philadelphia, Pennsylvania.**

Dr. Johnson was born in Cox's Creek, Kentucky, in 1906. He received his M. D. degree from the University of Pennsylvania Medical School in 1931 and a degree of Doctor of Medical Science from the Graduate School of University of Pennsylvania in 1939. At present he is Professor of Surgery in the University of Pennsylvania Medical School and also in the Graduate School of Medicine, University of Pennsylvania. He is an Associate Surgeon at the Hospital of the University of Pennsylvania and at the Philadelphia General Hospital and Senior Surgeon at the Children's Hospital, Philadelphia.

**3:30 "Angiography," Robert P. Ball, M. D., Cornell University, New York, New York.**

Dr. Ball was born in Harlan, Kentucky, and received his premedical education at Centre College. Following graduation from the University of Louisville School of Medicine and four years internship at Louisville General Hospital and at the Cleveland Clinic, he engaged in the private practice of medicine in Louisville and Harlan and later at Chattanooga, Tennessee. In 1936 he joined the staff of Presbyterian Hospital and the College of Physicians and Surgeons of Columbia University, New York City. For the past two years he has been Professor of Radiology and Radiologist-in-Chief at Cornell University Medical College and New York Hospital. He is now engaged in the private practice of clinical radiology at Baton Rouge, Louisiana. In 1948 he was awarded the degree of Doctor of Science, Honorary, by Centre College, Danville.

**4:00 "Deafness—Its Present Day Management," Arthur L. Juers, M. D., Miami, Florida.**

Dr. Juers was born in Lake City, Minnesota, in 1907 and received his premedical education at the University of Louisville as well as his M. D. degree in 1931. He was engaged in general practice in Providence, Kentucky, from 1932 to 1934 and practiced otolaryngology in Louisville from 1937 to 1945. He was Resident Physician in Otolaryngology at the University of Minnesota Hospital from 1934 to 1937, where he also had a teaching fellowship. Dr. Juers did experimental investigation in fenestration surgery at Northwestern University and taught in Northwestern Medical School's Department of Otolaryngology. He is now practicing otology in Miami and is research associate of experimental medicine in the Medical Research Unit, University of Miami, Coral Gables, Florida.

fields of medicine, including pediatrics, gynecology, psychiatry, surgery, etc.," said Dr. Clay.

For names of speakers, subjects and scheduling of lectures, see program below:

# **SEMINAR ON THERAPY**

Sponsored by

**The University of Louisville School of Medicine**

and

**The Kentucky State Medical Association**

**October 5, 1951**

**Louisville General Hospital**

- 8:30- 9:00 Registration
- 9:00- 9:15 Introduction and Orientation  
J. Murray Kinsman, M.D.
- 9:15- 9:45 Present Concepts in Treatment of Edema  
Herbert L. Clay, M. D.  
Maurice M. Best, M. D.
- 9:45-10:15 ACTH, Cortisone and Related Compounds  
James R. Hendon, M. D.
- 10:15-10:45 Antibiotics  
Lawrence T. Minish, M. D.
- 10:45-11:00 Intermission
- 11:00-11:30 Newer Trends in the Treatment of Common Skin Disorders  
Adolph B. Loveman, M. D.
- 11:30-12:00 Treatment of Anemias  
Marion F. Beard, M. D.
- 12:15- 2:00 Luncheon
- 2:00- 2:30 Recent Advances in Obstetrics and Gynecology Therapy  
William O. Johnson, M. D.,  
and Staff
- 2:30- 3:00 Recent Advances in Surgical Therapy  
R. Arnold Griswold, M. D.,  
and Staff
- 3:00- 3:15 Intermission
- 3:15- 3:45 Recent Advances in Psychiatric Therapy  
Spafford Ackerly, M. D.,  
Billy K. Keller, M. D.
- 3:45- 4:15 Recent Advances in Pediatric Therapy  
Leonard T. Davidson, M. D.,  
and Staff

Five hours credit for formal training will be given to those members of the Academy of General Practice who attend this Seminar.

## **Medical School Observes Centennial With Full Day Seminar**

The University of Louisville School of Medicine will participate in the Centennial Celebration by presenting a full day Seminar on Therapy, at Louisville General Hospital, Friday, October 5.

The program, sponsored by the University and the Kentucky State Medical Association, has been planned by Herbert L. Clay, M. D., Director of the Post-Graduate Refresher Training Department of the School of Medicine. Five hours credit will be given to members of the Academy of General Practice who attend.

Physicians may register for the course between 8:30 and 9:00 Friday morning at General Hospital. Nine lectures have been scheduled, five to be presented at the morning session and four to be heard in the afternoon.

J. Murray Kinsman, M. D., Dean of the Medical School, will give the welcome and introduce the program. Members of the Medical School faculty will present the lectures.

"The seminar is aimed primarily at physicians in General Practice as a refresher course to bring them up to date on recent advances in treatment in various



## REFERENCE COMMITTEES FOR CENTENNIAL SESSION

Appointees to the five Reference Committees and to the Credentials Committee of the House of Delegates to serve during the Annual (Centennial) Meeting of the Association, October 1, 2, 3 and 4, have been announced by Hugh L. Houston, M. D., Murray, Speaker of the House.

All annual reports of officers, committees and agencies of the Association, resolutions and new business must be made in writing and introduced at the first meeting of the House, Monday evening, October 1. (New business may be introduced at the second session of the house with the approval of the Council.) The Speaker will refer all these matters to the proper Reference Committees at that time.

On Tuesday afternoon the Reference Committees will meet and consider all matters presented to them. At this time any member of the Association interested in any of the issues or reports to be considered is urged and welcomed to attend the committee hearings and express himself. Full information on Reference Committees Meetings may be had at the Registration Desk.

After the committees have heard all interested parties and reviewed information presented to them, they will then consider the matter and make recommendation to the second meeting of the House, which is scheduled for 7:00 P. M., Wednesday, October 3. The House will then act on the recommendation of the Reference Committees.

Reference Committee No. 1 is the committee to consider Order and Rules of Business and Reports of Officers and Councilors. Members of the committee are:

E. M. Howard, Jr., M. D., Harlan, Chairman  
Thomas V. Gudex, M. D., Louisville, Vice-Chairman  
Theodore L. Adams, M. D., Lexington  
Luther Bach, M. D., Newport  
Robert L. Reeves, M. D., Paducah

Reference Committee No. 2 is the committee to study Reports of Standing Committees. Members of the committee are:

W. Vinson Pierce, M. D., Covington, Chairman  
Earl C. Yates, M. D., Lexington, Vice-Chairman  
Ralph L. Cash, M. D., Princeton  
Herbert L. Clay, Jr., M. D., Louisville  
Robert A. Orr, M. D., Mayfield

Reference Committee No. 3 is the committee to review Reports of Special Committees. Members of the committee are:

Walter L. O'Nan, M. D., Henderson, Chairman  
Richard J. Rust, M. D., Newport, Vice-Chairman

Arthur R. Kasey, M. D., Louisville  
Keith P. Smith, M. D., Corbin

B. Ralph Wilson, M. D., Sharpsburg

Reference Committee No. 4 is the committee to study Reports of Advisory Committees. The members of the committee are:

George W. Pedigo, M. D., Louisville, Chairman

Frank L. Duncan, M. D., Monticello, Vice-Chairman

O. Leon Higdon, M. D., Paducah

Harry K. Dillard, M. D., Warsaw

H. B. Mack, M. D., Pewee Valley

Reference Committee No. 5 is the committee to consider Resolutions. The members of the committee are:

Charles B. Stacy, M. D., Pineville, Chairman

Howell J. Davis, M. D., Owensboro, Vice-Chairman

James A. Outland, M. D., Murray

John D. Handley, M. D., Hodgenville

John W. Scott, M. D., Lexington

The Credentials Committee is composed of the following:

Henry V. Johnson, M. D., Georgetown, Chairman

Virgil G. Kinnaird, M. D., Lancaster, Vice-Chairman

Foster D. Coleman, M. D., Louisville

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## Golf Tournament Arranged

The Centennial Golf Tournament, sponsored by the Association, will be held at the Louisville Country Club, William C. Wolfe, M. D., Chairman of the Centennial Golf Committee, has announced.

Visiting physicians may play without charge for the greens fee at any time Monday, Tuesday, Wednesday or Thursday, October 1, 2, 3 or 4. Prizes will be awarded at the Centennial Banquet, Thursday evening, October 4.

Other members of the Golf Committee are George W. Pedigo, M. D., and Leo W. Zimmerman, M. D.

## THE CENTENNIUM: 1851-1951

Introspection as well as retrospection should have a place in any centennial celebration and this should be true especially for any group dedicated to the service of mankind. Progress in medicine and its ancillary sciences has been so great in the last century that, obviously, but comparatively few of the myriad of accomplishments can be mentioned in the space allotted for this editorial. To cover the field with any degree of thoroughness would require several volumes and many specialists, each writing of his own field.

Five years before our initial meeting the first successful public demonstration of the use of anesthetics in a surgical operation was made in Boston, Massachusetts, on 16 October 1846. Had the full implications of such an epochal event been recognized it would have seemed that a special report on anesthesia would have been included in our first program. Dr. Henry Miller, it is true, discussed the great value of anesthesia in obstetrical work before the 1852 meeting but Dr. Samuel D. Gross in the extensive report of the Committee on Surgery ignored the subject. To even cursorily discuss the progress in anesthesia alone would require much more than the allotted space. In all the larger hospitals there are now teams of anesthetists who are expert in the use of general, intravenous, and spinal anesthesia or combinations of them. Thus anesthesia in its own right has become a highly technical field necessitating specialization.

The century has, indeed, seen spectacular achievements in every branch of medicine. Beginning with Virchow who in the eighteen-fifties first taught that the body was "a cell-state in which every cell is a citizen," pathological research has revealed much of great significance. Bacteriology had its inception in the discoveries of Leeuwenhoek, father of this science, who described bacteria in 1676 and utilized incubation in their study. However, almost two hundred years elapsed before the discoveries of Pasteur and of Koch laid the foundation for the epochal advances in bacteriology which mark our first century as an Association. Pasteur it was who enunciated the theory of preventive inoculation which has meant so much in the modern fight against disease. Of the early pathologists and bacteriologists the name of Edwin Klebs

should be better known since as Garrison states, "He saw the typhoid bacillus before Eberth (1881), the diphtheria bacillus before Loeffler (1883), made solid cultures of bacteria and investigated the pathology of traumatic infections before Koch (1871)".

Modern surgery, while born when anesthetic agents were first employed, exhibited but a stunted growth until Joseph Lister in 1865 began his epochal work in antiseptics. Once his principles were firmly established progress in surgery was so accelerated that today we witness the safe invasion of every cavity of the body, including successful operations on the heart itself.

Surgery, in common with many other fields of medicine, has profited immensely by the discovery of the x-rays by Roentgen in 1895. At first thought to be applicable only to the location of dense foreign bodies and the presence of fractures, x-ray techniques have been developed to a point where they are useful in almost every special field either for diagnosis or treatment, and frequently for both.

It is an interesting coincidence that the discovery of radium followed so shortly, three years, after that of the x-rays. With radium there was an even longer lag than with the x-rays between the announcement of the discovery and its practical use.

Hypodermic needles, though used in the eighteen-forties, were not generally employed until long after our Association was organized. In 1851 clinical thermometers were occasionally used but their wide acceptance came several decades later. Although the blood pressure instrument was devised by von Basch in 1887, it was not adopted in the clinic until within my own memory. In fact, it was my privilege to present the first essay on blood pressure observations to be read and published in this state. Dozens of other instruments have been introduced into the clinic during the past fifty years including the electrocardiograph, the bronchoscope, the cystoscope, gastro-scope, encephalograph, etc.

In the field of chemistry discoveries have been frequent and often of great importance, such as radium, previously mentioned, salvarsan and the sulfon-



amides, among many. With the discovery of the antibiotics the physician's ability to combat disease has been increased immeasurably. One of the most spectacular results of antibiotic therapy is that achieved in the treatment of the hitherto uniformly fatal streptococcus viridans endocarditis. This once hopeless condition can now be cured with penicillin in more than eighty per cent of the cases.

In physiology the chemical approach has been applied with marked success as evidenced by dozens of important tests. Knowledge of the corpuscular elements of the blood as well as of its serum has progressed to an amazing degree since the early efforts in 1852 of Vierordt in making blood counts. Within the memory even of the youngest of us there have been spectacular advances in the haematological field and an important new specialty has emerged.

In the seventeenth century Leeuwenhoek with his simple lenses saw objects never before seen. Today, we observe a parallel in that the electron microscope has permitted magnifications never before possible and a hitherto invisible world has come into view.

The physicists have ushered us into the atomic age with potentialities which intrigue the imagination. Even in the early stages medicine is profiting by nuclear fission of the atom and we cannot begin to guess what vistas may open to medical science.

The progress in medical education during the Centennium has been as spectacular as that in other fields. In 1851 in Kentucky, as in practically all of the other states, one could begin treating the sick without ever having been inside a medical school. The mere announcement that one was a "doctor" was enough to bring one patients. A degree could be obtained from any one of the numerous medical schools after having attended two sessions of four to five months each. The lectures of the first session were repeated during the second, including even the jokes, it is said!

When our Association was organized there were three medical schools in the Commonwealth, one in Lexington, the Medical Department of Transylvania University, and two in Louisville, the Medical Department of the University of Louisville and the Kentucky School of Medicine. This last named school was in 1851 closely affiliated with the first mentioned

as evidenced by the fact that Benjamin W. Dudley was Emeritus Professor of Anatomy and Surgery and the following Transylvania professors held active chairs: Drs. Robert Peter, Samuel Annan, James M. Bush and Ethelbert L. Dudley. This arrangement was made possible by the fact that the lectures in Louisville began in November and continued until March while those at Transylvania began on 15 March and lasted four months. Kentuckians may well be proud of the fact that, at that time, the best two medical libraries in the United States were at Lexington (6,660 volumes) and in Louisville (3,316).

The Medical Department of Transylvania University finally closed its doors in 1859 and the Kentucky School of Medicine was held to be its lineal descendant. The two Louisville schools carried on, except for disruption during the Civil War, until 1866 when a merger was consummated which lasted only one brief session. Medical jealousies were at that time open and acrimonious, especially between the faculties of the colleges. To make matters worse, the Louisville Medical College was established in 1869 and the Hospital College of Medicine in 1874.

The Kentucky School of Medicine and the Louisville Medical College were so closely affiliated that their faculties were identical. The Louisville Medical College held its sessions from November to March and the Kentucky School of Medicine became a so-called "summer" school with sessions beginning in March and terminating about the first of August. Thus in the eighteen-seventies a student could enter a "winter" school in November for the first course of lectures, take his second in a "summer" institution and receive a degree in less than ten months.

Still another school was established in Louisville, the Jefferson School of Medicine, but was suspended after graduating one class. The situation at the time was but little different in other parts of the country. Even in Boston when President Eliot initiated the reform movement in medical education, he stated that Harvard "had no examination for admission and no standard of preliminary education. Anybody could walk into it from the street and many did walk in who could barely read and write." In 1893 the first really modern medical school in the United States was established by Johns Hopkins University with rigid entrance require-

ments and emphasis on research. Regardless of President Eliot's efforts and the example set by Johns Hopkins, medical schools continued to multiply in Louisville as elsewhere. The Southwestern Homeopathic Medical College and Hospital was founded in 1892 while Kentucky University Medical Department was organized in 1894.

The evils arising from too many medical schools in Kentucky and elsewhere were dramatically brought into focus by the Flexner report to the Carnegie Foundation for the Advancement of Teaching in 1910. Following this the American Medical Association took courageous action which initiated the eradication of the abuses. Through mergers the five regular medical schools in Louisville became the School of Medicine of the University of Louisville in 1909. By its own efforts it received a Class A rating which it has maintained up to the present. Thus the century which saw the development of so intolerable a situation in medical education witnessed also its correction to the point that the United States can now boast of the best medical schools in the world.

When we consider the vicissitudes and efforts of those who have built this structure we are forced to ask ourselves how we measure up. Truly, we stand on their shoulders and have infinitely more knowledge because of the discoveries mentioned and the countless ones unmentioned. However, there are few of us who devote to our profession the same amount of time and effort our predecessors gave. Rapid communications and transportation enable us to treat a far greater number of patients than did physicians of even the preceding generation. A century ago and for many decades thereafter couriers came for physicians and calls were answered on foot, on horseback, in open carts or, occasionally when roads were good, in carriages. I have heard elderly physicians relate stories of professional calls made on horseback during the winter when, to keep warm, they would dismount and walk miles to reach their patients. There are also the stories of those who forced their horses to swim across swollen streams. Today the physician in the most remote sections of our state undergoes no such hardships.

With our increased leisure there have come also additional distractions in diversions and amusements of many sorts, many of them worthy in themselves, but often inimical to the long hours of intensive study required of one who would keep fully informed. Advances in medicine are so rapid and numerous that unless a definite and considerable portion of our time be devoted to reading we will inevitably be practicing antiquated medicine. Samuel Johnson once said "All intellectual improvement arises from leisure," but it might be added *if used wisely*. When we review the devotion to science of such men as Ephraim McDowell, Benjamin W. Dudley, Charles Caldwell and Daniel Drake, to name but a few of Kentucky's early leaders in medicine, we may well be ashamed of our inadequacy.

Despite the progress during the past century there remain many and pressing problems which await solution. Cancer will some day yield to research. When we possess a fuller knowledge of the factors involved in arteriosclerosis and other processes of aging, the life span will no doubt be further lengthened. The most important unsolved problem in medicine today, that of hypertension, remains a riddle and a challenge to every physician.

Standing on the threshold of another century we should be mindful of the necessity of maintaining the confidence of the public. In the past, unfortunately, we have failed to realize the value of taking the laymen into our confidence. We have, at times, assumed that our deeds would speak for themselves. The public needs to be at all times informed of our ideals, of our problems, of our program and of our achievements. Only by spreading such information will it be possible to combat the repeated and erroneous claims of the quasi politico-sociologists that governmental controls alone can provide efficient and complete medical care for all. A wise move has been made by our Council in the employment of a person who is to devote his entire time to public relations. One further step seems advisable, the selection of a group of interested laymen in an advisory capacity who will interpret for us the viewpoint of the public.

EMMET F. HORINE



**PAST PRESIDENTS**  
Of the  
**KENTUCKY STATE MEDICAL ASSOCIATION**  
**1851 - 1951**



**W. L. SUTTON**  
1851-52



**W. S. CHIPLEY**  
1853



**SAMUEL D. GROSS**  
1854-55



**C. H. SPILLMAN**  
1856



**W. C. SNEED**  
1857



**W. T. OWEN**  
1858



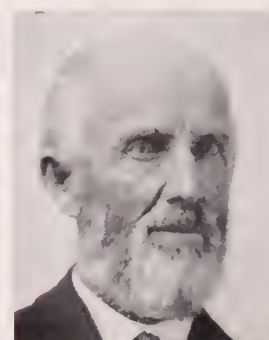
**JOSHUA B. FLINT**  
1859



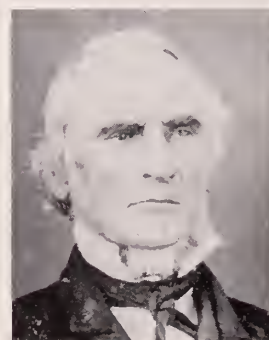
**C. P. MATTINGLY**  
1860



**BENJ. R. PALMER**  
1861



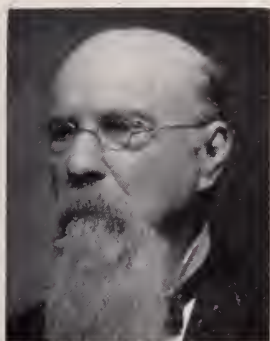
**D. N. PORTER**  
1867-68



**WILLIAM PAWLING**  
1869



**H. M. SKILLMAN**  
1870



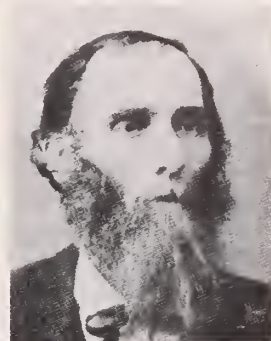
W. A. ATCHISON  
1871



T. N. WISE  
1872



LEWIS ROGERS  
1873



J. W. THOMPSON  
1874



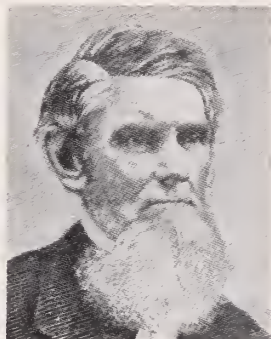
JERMAN BAKER  
1875



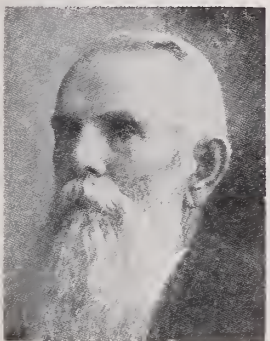
J. A. HODGE  
1876



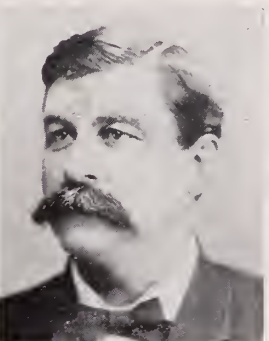
R. W. GAINES  
1877



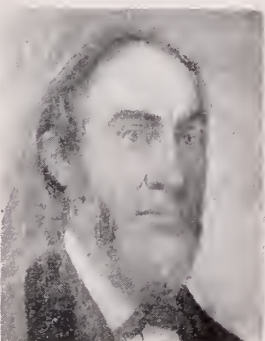
L. P. YANDELL, SR.  
1878 (Died in Office)



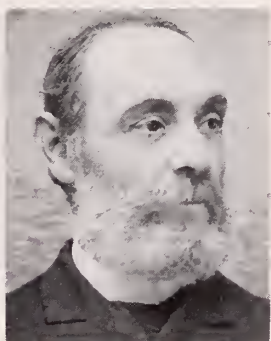
J. L. DISMUKES  
1878



CHARLES H. TODD  
1879



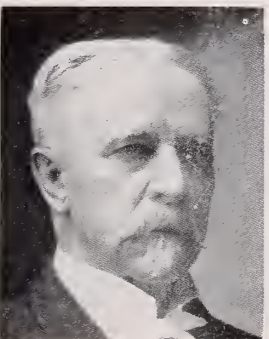
R. W. DUNLAP  
1880



LYMAN B. TODD  
1881



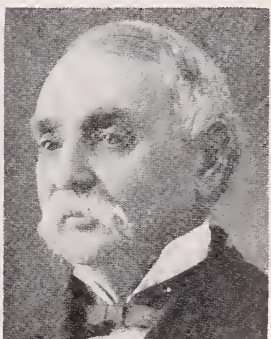
J. W. HOLLAND  
1882



ANCIL D. PRICE  
1883



J. N. MCCOMACK  
1884

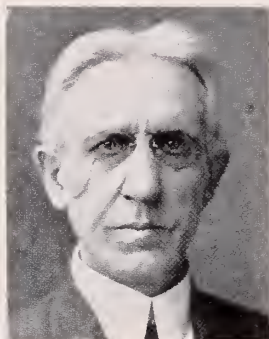


P. THOMPSON  
1885





JOS. P. THOMAS  
1886



W. H. WATHEN  
1887



JOHN G. BROOKS  
1888



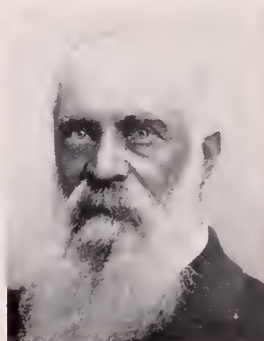
L. S. McMURTRY  
1889



J.A. OUCHTERLONY  
1890



GEORGE BEELER  
1891



HAWKINS BROWN  
1892



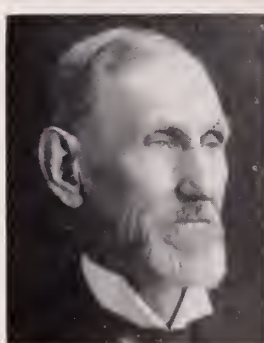
ARCH DIXON  
1893



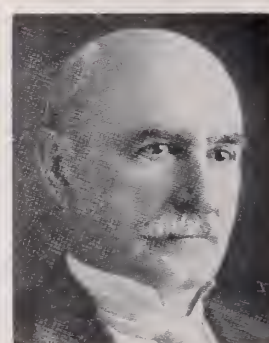
J. Q. A. STEWART  
1894



JOS. B. MARVIN  
1895



JOHN A. LEWIS  
1896



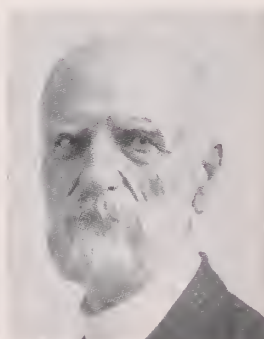
R. C. McCHORD  
1897



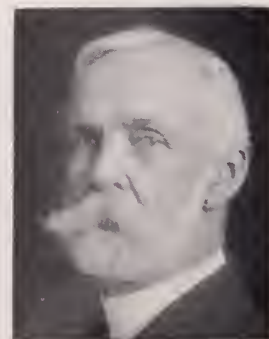
JOS. M. MATHEWS  
1898



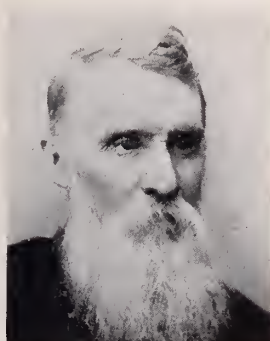
DAVID BARROW  
1899



WILLIAM BAILEY  
1900



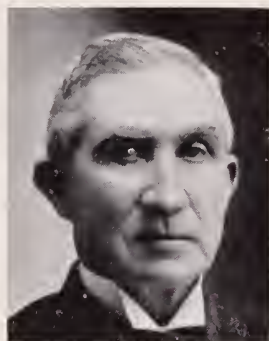
J. H. LETCHER  
1901



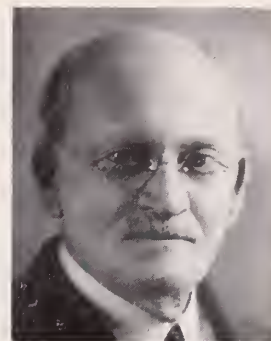
T. B. GREENLEY  
1902



W. W. RICHMOND  
1903



STEELE BAILEY  
1904



FRANK H. CLARKE  
1905



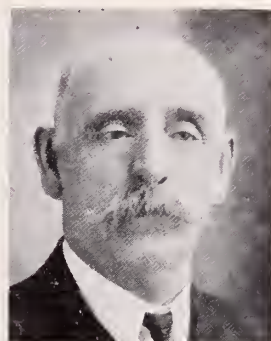
CHARLES Z. AUD  
1906



D. M. GRIFFITH  
1907



JOHN G. CECIL  
1908



ISAAC A. SHIRLEY  
1909



JOSEPH E. WELLS  
1910



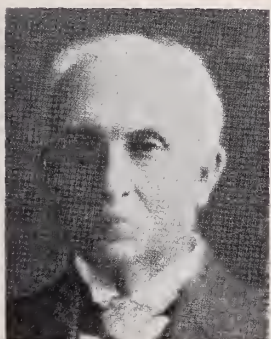
J. G. CARPENTER  
1911



DAVID O. HANCOCK  
1912



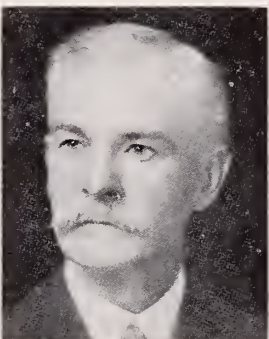
W. O. ROBERTS  
1913



JAMES W. ELLIS  
1914 (Died in Office)



JOHN J. MOREN  
1914



J. W. KINCAID  
1915



MORGAN VANCE  
1916 (Died in Office)





MILTON BOARD  
1916



P. H. STEWART  
1917



J. S. LOCK  
1918



J. G. SOUTH  
1919



W. W. ANDERSON  
1920



J. A. STUCKY  
1921



LOUIS FRANK  
1922



FRANK BOYD  
1923



J. RICE COWAN  
1924



R. L. WOODARD  
1925



IRVIN ABELL  
1926



R. JULIAN ESTILL  
1927



J. H. BLACKBURN  
1928



G. S. HANES  
1929



W. B. McCLURE  
1930



J. T. REDDICK  
1931



P. F. BARBOUR  
1932



W. M. MARTIN  
1933



C. C. HOWARD  
1934



J. B. LUKINS  
1935



J. D. NORTHCUTT  
1936



H. G. REYNOLDS  
1937



W. E. GARDNER  
1938



JOHN W. SCOTT  
1939



AUSTIN BELL  
1940 (Died in Office)



W. E. GARY  
1940



E. L. HENDERSON  
1941



E. M. HOWARD  
1942



VAN A. STILLEY  
1943 (Died in Office)



J. H. PRITCHETT  
1943



OSCAR O. MILLER  
1944



J. WATTS STOVALL  
1945





E. W. JACKSON  
1946



GUY AUD  
1947



CHARLES A. VANCE  
1948



HUGH L. HOUSTON  
1949

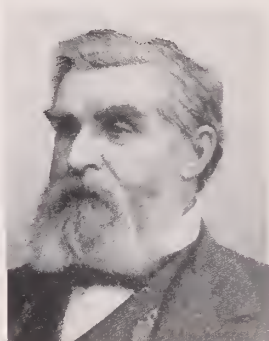
### PAST SECRETARIES



W. C. SNEED  
1851-1856



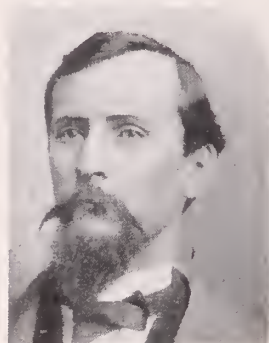
T. G. RICHARDSON  
1857-1858



S. M. BEMISS  
1859



S. P. PRECKINRIDGE  
1869



JOHN D. JACKSON  
1871



J. A. LARRABEE  
1873-1875



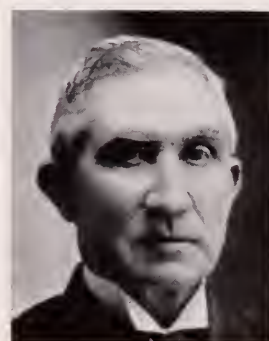
JAMES H. LETCHER  
1877-1879



ARCH DIXON  
1880



L. S. McMURTRY  
1881-1883



STEELE BAILEY  
1886-1903



A. T. McCORMACK  
1907-1943



P. E. BLACKERBY  
1943-1948

## Association Has Had Twenty Secretaries During Centennium

The Kentucky State Medical Association has had twenty secretaries in its hundred years of existence, including the present incumbent. They were:

W. C. Sneed, M. D., 1851-1856  
 Tobias G. Richardson, M. D., 1857-1858  
 Samuel M. Bemiss, M. D., 1859  
 Preston B. Scott, M. D., 1868  
 Stanhope P. Breckinridge, M. D., 1869  
 M. E. Poynter, M. D., 1870  
 John D. Jackson, M. D., 1871  
 William B. Rodman, M. D., 1872  
 C. F. Ulrich, M. D., 1872  
 J. A. Larrabee, M. D., 1873-1875  
 J. W. Singleton, M. D., 1876  
 James H. Letcher, M. D., 1877-1879  
 Arch Dixon, M. D., 1880  
 Lewis S. McMurtry, M. D., 1881-1883  
 Samuel M. Letcher, M. D., 1884-1885  
 Steele Bailey, M. D., 1886-1903  
 James B. Bullitt, M. D., 1904-1906  
 Arthur T. McCormack, M. D., 1907-1943  
 Philip E. Blackerby, M. D., 1943-1948  
 Bruce Underwood, M. D., 1948-

Drs. Sneed, J. H. Letcher, Dixon, McMurtry and Bailey also served the Association as president.

Dr. Arthur T. McCormack was elected as Secretary of the Association in 1907 and served until his death in 1943. To him, more than to any other individual, belongs the credit for many of the heritages of the Association that will be celebrated during the Centennial Meeting. His outstanding capability is clearly reflected in the remarkable progress made by the Association during the 36 years of his leadership. Although national recognition came to him, he was never president of the Association. He is said to have refused the office on many occasions when his fellows urged him to accept the office in reward for the great contribution that he made to the Association. He felt that his greatest opportunity for service lay in the office of secretary and willingly sacrificed the honor of the presidency. His father, J. N. McCormack, M. D., served as president but was never secretary. He did, however, serve as Acting Secretary during the period from 1917 to 1919 when Dr. Arthur was in service in the Panama Canal Zone.

Dr. Philip E. Blackerby was elected Secretary upon the death of his illustrious predecessor with whom he had been close-

ly associated for many years. His loyalty to the profession, his interest in the affairs of the Association, his energetic leadership and the charm of his personality won for him the love and respect of the membership.

Dr. Blackerby served for five years, until his unfortunate death in 1948.

## Delegates, Schedule of Sessions For Centennial Announced

The House of Delegates at the Annual (Centennial) Meeting of the Association will hold its first session Monday evening, October 1, in the Columbia Auditorium, with registration starting at 6:00 P. M., and the meeting opening at 7:00 P. M., Central Standard Time.

The second session of the House is scheduled for 7:00 P. M. Wednesday evening in the Columbia Auditorium. The Reference Committees of the House will meet Tuesday afternoon.

Delegates who will represent the component County Medical Societies of the Association, and who have been reported to the Headquarters Office before the deadline for this issue, are listed below. Delegates are appointed on the basis of one delegate for every 25 members or major fraction thereof.

### DELEGATES - 1951

**Adair:** M. C. Loy, Columbia  
**Allen:** John W. Meredith, Scottsville  
**Anderson:**  
**Ballard:**  
**Barren:** William C. Wells, Glasgow  
**Bath:** B. Ralph Wilson, Sharpsburg  
**Bell:** Charles B. Stacy, Pineville  
**Boone:** Gladys L. Rouse, Florence  
**Bourbon:** J. C. Hart, Paris  
**Boyd:** S. C. Smith, Ashland; Wendell V. Lyon, Ashland  
**Boyle:** R. G. Jackson, Danville  
**Bracken:** J. M. Stevenson, Brooksville  
**Breathitt:** F. C. Lewis, Jackson  
**Breckenridge:** John A. Kincheloe, Hardinsburg  
**Bullitt:** James O. Willoughby, Shepherdsville  
**Butler:** D. G. Miller, Jr., Morgantown  
**Caldwell:** Ralph L. Cash, Princeton  
**Calloway:** James A. Outland, Murray  
**Campbell-Kenton:** W. V. Pierce, Covington; Richard J. Rust, Newport; O. W. Frickman, Newport; Maurice R. Walsh, Covington; Luther Bach, Newport  
**Carlisle:** E. E. Smith, Bardwell  
**Carroll:** H. Carl Boylen, Carrollton



- Carter:** Grady Stewart, Olive Hill  
**Casey:** Garnett J. Sweeney, Liberty  
**Christian:** Guinn S. Cost, Hopkinsville  
**Clark:**  
**Clay:** W. E. Nichols, Manchester  
**Clinton:** E. A. Barnes, Albany  
**Crittenden:** James O. Nall, Marion  
**Cumberland:** Wm. Fayette Owsley, Burkesville  
**Daviess:** William L. Woolfolk, Owensboro;  
 Howell Davis, Owensboro  
**Edmonson:** Marcus B. Wilkes, Jr., Brownsville  
**Elliott:** John F. Greene, Sandy Hook  
**Estill:** R. R. Snowden, Ravenna  
**Fayette:** John Scott, Lexington; N. L. Bosworth, Lexington; Theodore L. Adams, Lexington; Richard G. Elliott, Lexington; Lawrence E. Hurt, Lexington; E. Carroll Yates, Lexington  
**Fleming:** John R. Cummings, Flemingsburg  
**Floyd:** George P. Archer, Prestonsburg  
**Franklin:** T. P. Leonard, Frankfort  
**Fulton:** Glynn Bushart, Fulton  
**Gallatin:** Harry K. Dillard, Warsaw  
**Garrard:** V. G. Kinnaird, Lancaster  
**Grant:** C. C. Waldrop, Williamstown  
**Graves:** Robert A. Orr, Mayfield  
**Grayson:**  
**Green:** J. M. Dishman, Greensburg  
**Greenup:** C. B. Johnson, Russell  
**Hancock:**  
**Hardin:** C. H. Long, Elizabethtown  
**Harlan:** Philip J. Begley, Harlan; E. M. Howard, Harlan  
**Harrison:** John P. Wyles, Cynthiana  
**Hart:** Colby Nelson Cowherd, Munfordsville  
**Henderson:** W. L. O'Nan, Henderson  
**Henry:** Wyatt Norvell, Newcastle  
**Hickman:** Vester A. Jackson, Clinton  
**Hopkins:** Loman Trover, Earlington  
**Jackson:**  
**Jefferson:** George F. Archer, Louisville; J. Randolph Buskirk, Louisville; Herbert L. Clay, Jr., Louisville; Foster D. Coleman, Louisville; John D. Gordinier, Louisville; Thomas Van Zandt Gudex, Louisville; Arthur R. Kasey, Jr., Louisville; Marvin A. Lucas, Louisville; Charles H. Maguire, Louisville; Roy H. Moore, Jr., Louisville; Malcom D. Thompson, Louisville; Byron Bizot, Louisville; Carlos A. Fish, Louisville; Laman A. Gray, Louisville; Robertson O. Joplin, Louisville; Selby V. Love, Louisville; Paul Mapother, Louisville; Robert F. Monroe, Louisville; Carlisle Morse, Louisville; George W. Pedigo, Jr., Louisville; Harper E. Richey, Louisville; Henry G. Saam, Louisville; Rudy F. Vogt, Louisville; James E. Winter, Louisville  
**Jessamine:** C. A. Neal, Nicholasville  
**Johnson:**  
**Knott:** M. F. Kelly, Hindman  
**Knox:** T. R. Davies, Barbourville  
**Larue:** J. D. Handley, Hodgenville  
**Laurel:** D. D. Turner, London  
**Lawrence:** Hobart Lester, Louisa  
**Lee:**  
**Leslie:**  
**Letcher:** B. C. Bach, Whitesburg  
**Lewis:**  
**Lincoln:** H. I. Frisbie, Stanford  
**Livingston:**  
**Logan:** Carlisle Dodson, Russellville  
**Lyon:** M. H. Moseley, Eddyville  
**McCracken:** Robert Reeves, Paducah; Leon Higdon, Paducah  
**McCreary:** Marcus D. Haley, Whitley City  
**McLean:** A. B. Colley, Calhoun  
**Madison:** Harold H. Rutledge, Richmond  
**Magoffin:**  
**Marion:** S. Cooper Clarkson, Lebanon  
**Marshall:**  
**Martin:**  
**Mason:** W. H. Cartmell, Maysville  
**Meade:** Alfred Glattauer, Brandenburg  
**Menifee:** Donald L. Graves, Frenchburg  
**Mercer:** T. O. Meredith, Harrodsburg  
**Metcalf:** Elgin S. Dunham, Edmonton  
**Monroe:** Tim L. Carter, Tompkinsville  
**Montgomery:** Joe M. Bush, Mt. Sterling  
**Morgan:** Ralph Gullett, West Liberty  
**Muhlenberg:** G. H. Rodman, Greenville  
**Nelson:** K. L. Stinnette, Bardstown  
**Nicholas:** Jack T. Morford, Carlisle  
**Ohio:** Oscar Allen, Beaver Dam  
**Oldham:** J. T. Walsh, LaGrange  
**Owen:** James T. Ramsey, Owenton  
**Owsley:** Don E. Wilder, Booneville  
**Pendleton:** Hallett A. Lewis, Falmouth  
**Perry:** C. Dana Snyder, Hazard  
**Pike:** J. E. Johnson, Stone  
**Powell:**  
**Pulaski:** A. B. Morgan, Somerset  
**Robertson:** Perry Overby, Mt. Olivet  
**Rockcastle:** George G. Griffith, Mt. Vernon  
**Rowan:**  
**Russell:** Walter B. Miller, Russell Springs  
**Scott:** H. V. Johnson, Georgetown  
**Shelby:** H. B. Mack, Pewee Valley  
**Simpson:**  
**Spencer:**  
**Taylor:** C. V. Hiestand, Campbellsville  
**Todd:** Ralph D. Lynn, Elkton  
**Trigg:** G. E. Hatcher, Cerulean  
**Trimble:** O. James Hurt, Bedford  
**Union:** George Welker, Morganfield  
**Warren:** A. D. Donnelly, Jr., Bowling Green  
**Washington:** Richard A. Hamilton, Springfield  
**Wayne:** Frank L. Duncan, Monticello  
**Webster:** William W. Wainer, Providence  
**Whitley:** K. P. Smith, Corbin  
**Wolfe:**  
**Woodford:** C. Noel Hall, Versailles

## "CENTENNIAL CAPSULES"

**Members and guests will register** at the Registration Booth in the west end of the exhibit hall. Registration will open at 8:00 A. M., Tuesday, October 2.

**The Public Meeting** will be held at the Columbia Auditorium, Tuesday evening, October 2. Lewis J. Moorman, M. D., will share the spotlight with a unique program built around Ephraim McDowell.

**The President's Luncheon**, honoring distinguished visitors, will be held in the Roof Garden of the Brown Hotel at 12:00 A. M., Wednesday, October 3. John W. Cline, M. D., San Francisco, A.M.A. President, will be the principal speaker. Purchase your tickets at Registration Desk or Education Sub-Committee Booth.

**The Centennial Banquet** is scheduled for Thursday evening, October 4, in the Crystal Ballroom of the Brown Hotel. "Golden Spikes" is the title of the President's address. Other features include recognition of Reunion Classes, inaugural ceremonies and dancing. Tickets may be purchased at Registration Desk or Education Sub-Committee Booth.

**The House of Delegates** first meeting will be held at 7:00 P. M., Monday, October 1, in the Columbia Auditorium, registration of Delegates starting at 6:00 P. M., Central Standard Time. The second meeting will be held at the same location, Wednesday evening at 7:00 P. M., October 3.

**The Woman's Auxiliary** to K. S. M. A. will hold their meeting in the Brown Hotel. Auxiliary Registration Desk will be in the lobby of the hotel. Auxiliary members are also urged to attend meetings and exhibits at the Auditorium.

**The Scientific Exhibits** will be attractively staged in the exhibit hall at the Auditorium. Twenty-five carefully selected exhibits, occupying over 500 feet of wall space, will be a must on your agenda.

**WAbash 6903** is the Special Centennial Meeting telephone number that you should leave with your home, office or hospital if you wish to be reached on short notice while attending the Centennial Session at the Columbia Auditorium. This phone, for incoming calls only, will be located in the temporary Headquarters Office.

**Classes of '01, '11, '21, '31 and '41** of the University of Louisville School of Medicine are having reunions during the Centennial. They will have special tables at the Centennial Banquet and will be recognized.

**Our Technical Exhibitors** are asked to talk only with attendants wearing official badges. This request is made for your convenience and as a protective measure for both you and the exhibitors.

**The Historical Exhibits** will be found immediately inside the main entrance of the Columbia Auditorium on the north side. You will be delighted with the beautiful presentation of this authentic material.

**A Temporary Bus Stop** for your convenience, serving in and out bound traffic, has been arranged at the main entrance of the Columbia Auditorium.

**Reference Committee Meetings** will be held Tuesday afternoon in the same location as last year, immediately under the auditorium. Specific information will be given you at the House of Delegates Monday evening session.

**The Centennial Volume** will be a lasting and valuable memento of our first hundred years. It will contain all papers presented at the Meeting, photographs and biographical sketches of essayists, plus a biography of Ephraim McDowell and a history of K.S.M.A. prepared by Emmet F. Horine, M. D. Place your order for one or more copies at the table near the Registration Desk.

**Scientific Movies** will be shown continuously in the basement lounge. This room is located at foot of stairway leading off main hall near entrance of Auditorium.

**A Thirty Minute Intermission** during each morning and afternoon scientific session has been scheduled in order that you may have an opportunity to visit commercial, historical and scientific exhibits. There are a total of 95 exhibits in the three classifications. Be sure to see all three.

**The Education Sub-Committee** will have a booth at the entrance of the exhibit hall. Maintained for your convenience, you may leave your packages there, sit in comfortable chairs while waiting for a friend, order campaign literature, get information you may require—and buy your tickets to the President's Luncheon and the Centennial Banquet.

**Parking Space** in large lots may be found on either side of Fourth Street between the Auditorium and Broadway. Do not park in the alley to the rear of the Auditorium.



## Twenty-Five Scientific Exhibits to be Presented

The Committee on Scientific Exhibits for the Centennial Meeting will present 25 carefully selected exhibits, many from nationally known groups, occupying more than 500 feet of wall space at the Columbia Auditorium, Everett L. Pirkey, M. D., Chairman of the Committee, has announced.

Expense has not been spared in making space available and in properly presenting the exhibits. Unusual care has been taken to present a well-balanced, highly profitable exhibit, Dr. Pirkey said.

A thirty minute intermission during each morning and afternoon Scientific Session has been scheduled in order that you may have an opportunity to see these displays. The committee urges you to visit their exhibits.

A summary of the Scientific Exhibits follows:

### Space No. 1. Recent Advances in Plastic Surgery

C. J. Armstrong, M. D., Louisville

John C. Weeter, M. D., Louisville

A presentation of photographs of methods used in plastic and reconstructive surgery is given, as applied to congenital deformities, hemangiomas, skin malignancies, scars, and facial bone fractures.

### Space No. 2. Gastric Cancer, Its Diagnosis and Treatment

Coleman C. Johnston, M. D., Lexington

A gastroscope and dummy stomach will be shown. Colored slides of gastroscopic views of stomach pathology with photographs of the gross lesions and some of the patients will be presented. The problem of gastric carcinoma, with a review of the approved methods of early diagnosis and radical treatment, will be shown.

### Space No. 3. Bilateral Mastectomy for Breast Cancer

George B. Sanders, M. D., Louisville

Roy H. Moore, Jr., M. D., Louisville

Breast cancer is a systemic disease on an endocrine-hereditary-predisposition basis. The incidence of bilateral breast cancer and the location of the lesion determines the selection of cases for bilateral operation and the extent of such an operation.

### Space No. 4. Carcinoma of the Breast

Houston W. Shaw, M. D., Louisville

Tables and illustrations are presented of the problem of carcinoma of the breast as seen at

the Louisville General Hospital over the past ten years, including the end results of treatment.

### Space No. 5. Radiological Terminology in Carcinoma of the Cervix

Jesshill Love, M. D., Louisville

Definitions of stages of malignant disease and radiation terminology will be given. Models and diagrams will demonstrate the distribution of radiation achieved in the human pelvis in the treatment of carcinoma of the uterine cervix.

### Space No. 6. Aspiration Biopsy Technique

William M. Christophersen, M. D., Louisville

Aura J. Miller, M. D., Louisville

This exhibit consists of illustrations demonstrating the technique of needle aspiration of tumors, together with photomicrographs of representative smears of assorted neoplasms.

### Space No. 7. Poly Viso Four Channel Recorder

Walter S. Coe, M. D., Louisville

Maurice Best, M. D., Louisville

A demonstration is given of the recording of intravascular pressures simultaneously with the electrocardiogram by means of the cardiac catheter, electromanometer and poly viso four channel recorder.

### Space No. 8. Educational Electron Cardioscope

J. Murray Kinsman, M. D., and Staff, Louisville

A demonstration is given of the Cambridge Educational Electron Cardioscope in the teaching of cardiovascular disease.

### Space No. 9. Ballistocardiograph

Herbert L. Clay, Jr., M. D., Louisville

The actual taking of a ballistocardiograph on a subject will be demonstrated. Charts giving examples of ballistocardiographs on subjects with different diseases will be shown.

### Space No. 10. Heart Disease—Vital Statistics

M. M. Weiss, M. D., Louisville

G. R. Jones, M. D., Louisville

Charts and diagrams will be presented to give a graphic demonstration of the present day role played by heart disease.

### Space No. 11. The Role of the Clinical Laboratory in Diagnosis and Therapy

The Kentucky State Society of Medical Technologists

1. The laboratory control of effective antibiotic therapy—chart and culture plates showing the effect of several antibiotics. 2. The value

of the Coombs' reaction in Rh testing and antibody studies. 3. Recent interpretations of prothrombin time. 4. A survey of blood transfusion reactions.

**Space No. 12. The Blue Shield Medical Care Plan**

Kentucky Physicians Mutual, Inc.

Graphs and charts will present the story of growth, financial status, and physician participation in the Blue Shield Plan.

**Space No. 13. Radioisotopes in Medicine**

United States Atomic Energy Commission, Isotopes Division, Oak Ridge, Tennessee  
Charts demonstrating the use of radioisotopes in diagnosis, treatment, and research will be presented. Protection problems will be discussed.

**Space No. 14. The Effects of Ionizing Radiation**

Franklin H. Grauer, Col., M. C., U. S. Army  
Robert R. Thompson, Col., M. C., U. S. Army  
June C. Shafer, M. D., Washington, D. C.  
Ernest R. Trice, Capt., M. C., U. S. Army

The effects of total body x-radiation in the dog examples of cutaneous damage following superficial radiation, and results of atomic explosion will be shown.

**Space No. 15. The Story of Air Force Medicine**

The Medical Service, United States Air Force, Washington, D. C.

The development of and the present-day activities of the Medical Service of the Air Force will be graphically presented.

**Space No. 16. Electroencephalography**

L. Levy, M. D., Louisville  
R. P. Schmidt, M. D., Louisville  
R. Turrell, M. D., Louisville  
E. Roseman, M. D., Louisville

An outline of the theory and principles of electroencephalography (EEG), with a demonstration of some of its uses, will be given.

**Space No. 17. Definitive and Differential Diagnosis of Poliomyelitis**

Hart Van Riper, M. D., New York, New York

The exhibit presents pertinent data on symptomatology, muscles and nerves most frequently involved, traumatizing factors, the physical examination and laboratory findings, all of which contribute to making a differential diagnosis of poliomyelitis.

**Space No. 18. The American Academy of General Practice**

**Space No. 19. Methods of Bone Fixation Permitting Early Function**

W. K. Massie, M. D., Lexington  
O. B. Murphy, M. D., Lexington

1. Illustrations of the use of both the Kuntsch-

ner and Rush nails in the most propitious conditions. 2. Uses of intramedullary fixation to permit early function after joint fusion. 3. Subtrochanteric osteotomy combined with nail fixation of femoral intracervical fractures to promote healing and early weight bearing.

**Space No. 20. The Management of Deafness**

Arthur L. Juers, M. D., Miami, Florida

The practical aspects of the differential diagnosis of deafness are outlined. Case abstracts are used to illustrate management of various types of deafness. A series of wax models in color is presented to show the current technic of fenestration surgery.

**Space No. 21. Miscellaneous Gross Lesions Involving Ear, Nose, and Throat**

George Uhde, M. D., Louisville

Harold Gordon, M. D., Louisville

This exhibit consists of representative gross lesions, mounted in plastic containers. Each specimen is accompanied by a caption with a brief clinical abstract and description of the lesion which is being displayed.

**Space No. 22. A Method for Displaying Gross Specimens**

Harold Gordon, M. D., Louisville

David Shapiro, M. D., Louisville

The exhibit will be composed of miscellaneous but representative gross lesions encased in plastic containers, and provided with a caption detailing the salient clinical and gross pathologic features of the specimens. In addition, the caption includes a black and white print of the correlated roentgenologic changes.

**Space No. 23. Abdominal Aortography**

David Shapiro, M. D., Louisville

Joseph C. Bell, M. D., Louisville

Everett L. Pirkey, M. D., Louisville

A series of films illustrate technic, indications and diagnostic value of abdominal aortography. These include positioning of patient, anatomy, and normal and abnormal findings.

**Space No. 24. Varicose Veins and Stasis Ulcers**

D. W. Barrow, M. D., Lexington

D. A. Hull, M. D., Lexington

Pictures and clinical records of patients with varicose veins and stasis ulcers will be presented.

**Space No. 25. Early Kentucky Medicine**

Miss Blake Beem, Louisville

Miss Georgia Price, Chicago, Illinois

Miss Elizabeth F. Carr, Chicago, Illinois

The exhibit will consist mainly of books, pictures and instruments representing early medicine in Kentucky—original publications of Kentucky physicians, catalogues of the earliest medical schools, pictures of prominent individuals, etc. It will cover the period up to and including 1851.



## OFFICIAL CALL

### ANNUAL MEETING

### KENTUCKY STATE MEDICAL

### ASSOCIATION

To the officers and members of the component county societies of the Kentucky State Medical Association.

#### Meeting Place

The Centennial Meeting of the Kentucky State Medical Association will convene at the Columbia Auditorium, Louisville, on Monday, Tuesday, Wednesday, and Thursday, October 1-4, 1951. The General Session will be called to order at 9:00 A. M. and the First Scientific Session will begin at 9:15 A. M., Tuesday, October 2.

#### The House of Delegates

The First Regular Session of The House of Delegates will convene at 7:00 P. M., Monday, October 1; the Second Regular Session will begin at 7:00 P. M., Wednesday, October 3. Both sessions will be held in the Columbia Auditorium.

#### Registration

The Registration Department will be open in the Columbia Auditorium from 6:00 P. M. to 8:00 P. M. on Monday, October 1; from 9:00 A. M. to 5:00 P. M. on Tuesday, October 2; from 9:00 A. M. to 5:00 P. M. on Wednesday, October 3; and from 9:00 A. M. to 5:00 P. M. on Thursday, October 4.

### WOMAN'S AUXILIARY

#### To The

### KENTUCKY STATE MEDICAL ASSOCIATION

**Tuesday, October 2, 1951, Brown Hotel**

Preconvention Board Breakfast, 8:00 A. M., Louis XVI Room; Formal opening of the Twenty-Ninth Annual Meeting, 10:00 A. M., South Room; Informal Tea Honoring Distinguished Guests, 3:00 P. M., South Room.

**Wednesday, October 3, Brown Hotel**

Morning Session, 9:00 A. M., South Room; Afternoon Session, beginning with a Subscription Luncheon and Style Show, 12:30 P. M., Crystal Ballroom.

**Thursday, October 4, Brown Hotel**

Subscription Breakfast and Post-Convention Board of Directors Meeting, 8:00 A. M.

### Registration

The Registration Department of the Woman's Auxiliary will be open in the North Bay of the Lobby, Brown Hotel, on Monday, October 1, from 12:00 Noon to 5:00 P. M.; Tuesday, October 2, from 9:00 A. M. to 5:00 P. M.; Wednesday, October 3, 9:00 A. M., to 12:00 Noon.

### Special Phone, WA. 6903, Arranged For Centennial Attendance

If you wish to be reached in the minimum length of time while attending the Centennial Meeting at the Columbia Auditorium, October 2, 3 and 4, have those who want you call Louisville—WABash 6903.

Through special arrangements with the Telephone Company, the Association will have a number in the temporary Headquarters Office at the Auditorium, for incoming calls only. Four pay stations are conveniently located for outgoing calls.

### Mayor's Office Okehs Bus Stop

A temporary bus stop for both in and out bound traffic has been arranged in front of the Columbia Auditorium, especially for the convenience of Centennial attendants.

Permission to set up the special stop was granted by the Mayor's office to the Transit Company, and the Headquarters Office is most grateful for the cooperation.

### Selection of Delegates Outlined

The attention of County Societies who have not sent in the name of their delegate is called to Chapter IV, Section 2, of the By-Laws:

"In the event there is no duly authorized delegate in attendance at the regular meeting of the House of Delegates the President shall consult any duly elected officer of the component society who is in attendance and with the approval of the Credentials Committee may appoint any active member of the component society in attendance at the meeting as the delegate. In the event there is no duly elected officer of the component society in attendance, the President may make the said appointment with the approval of the Credentials Committee. All appointments made shall also be with the approval of the House of Delegates."

**TWENTY-NINTH ANNUAL MEETING**  
**of the**  
**WOMAN'S AUXILIARY**  
**to the**  
**Kentucky State Medical Association**  
**SOUTH ROOM, BROWN HOTEL**  
**Louisville, Kentucky**  
**October 2-3-4, 1951**

**REGISTRATION HOURS:**

North Bay of Lobby, Brown Hotel  
 Monday—Noon to 5:00 P. M.  
 Tuesday—9:00 A. M. to 5:00 P. M.  
 Wednesday—9:00 A. M. to 12:00 Noon

Chairman of  
 Registration.....Mrs. R. R. Slucher  
 Buechel

**Tuesday, October 2**

8:00 A. M.

Louis XVI Room, Brown Hotel

Pre-Convention Board Breakfast (subscription)  
 The Board consists of all elected state officers,  
 councilwomen, state committee chairmen and  
 county auxiliary presidents.

**Tuesday, October 2**

10:00 A. M.

South Room

Formal opening of the Twenty-Ninth Annual  
 Meeting of the Woman's Auxiliary to the  
 Kentucky State Medical Association.

Presiding.....Mrs. Clark Bailey  
 President, Harlan

Invocation.....Mrs. Edward Wilson, Jr.  
 Pineville

Pledge of Allegiance

to Flag.....Mrs. E. W. Jackson  
 Immediate Past President  
 Paducah

Pledge of Loyalty.....Mrs. E. W. Jackson  
 I pledge my loyalty and devotion to the  
 Woman's Auxiliary to the American Medi-  
 cal Association. I will support its activities,  
 protect its reputation and ever sustain its  
 high ideals.

Address of Welcome.....Mrs. A. R. Kasey, Jr.  
 President, Jefferson County  
 Auxiliary, Louisville

Response. ....Mrs. Keith Smith  
 Corbin

In Memoriam.....Mrs. John Floyd  
 Richmond

Presentation of Convention

Chairman.....Mrs. John Gordinier  
 Louisville

Presentation of Distinguished Guests

Roll Call.....Mrs. C. Melvin Bernhard  
 Secretary, Louisville

Minutes of Twenty-Eighth Annual

Meeting.....Mrs. C. Melvin Bernhard

Report of 1951 National

Convention.....Mrs. Karl D. Winter  
 Louisville

Report of Councilor of Woman's Auxiliary  
 to Southern Medical

Association.....Mrs. Walker Owens  
 Mt. Vernon

**REPORTS OF OFFICERS:**

Treasurer.....Mrs. A. B. Colley  
 Calhoun

President-Elect.....Mrs. John Harter  
 Louisville

President.....Mrs. Clark Bailey

Old Business

New Business

Report of Nominating

Committee....Mrs. E. W. Jackson, Chairman  
 Election of Nominating Committee 1952-53

Presentation of 1951-52

Budget.....Mrs. Hugh L. Houston  
 Murray

Report of Registration.....Mrs. R. R. Slucher

**Recess**

**Tuesday, October 2**

3:00 P. M.

South Room

Tea Honoring Distinguished Guests (Informal)

Guest Speaker.....Mrs. H. B. Ritchie  
 Athens, Georgia

**Tuesday, October 2**

8:00 P. M.

Annual Public Meeting, Columbia Auditorium  
 Speaker, Lewis J. Moorman, M. D.—“Ken-  
 tucky, the Progenitor of Pioneer Doctors”

The Auxiliary will present living pictures de-  
 picting the history of the McDowell House.

**Wednesday, October 3**

9:00 A. M.

South Room

Reading of Minutes..Mrs. C. Melvin Bernhard

Roll Call.....Mrs. C. Melvin Bernhard

Announcements.....Mrs. John Gordinier  
 Convention Chairman

Report of Revisions

Committee.....Mrs. Grace Reynolds  
 Chairman, Paducah

Old Business

New Business



### Election of Officers Program:

Guest Speaker.....Mrs. L. S. Thompson  
President, Woman's Auxiliary to  
Southern Medical Association  
Dallas, Texas

### Wednesday, October 3

Crystal Ballroom  
12:30 P. M.

### Subscription Luncheon and Style Show

To Honor: Mrs. L. S. Thompson and Mrs.  
Harold F. Wahlquist

Invocation.....Mrs. E. W. Waldemayer  
Greetings.....Kentucky State Medical  
Association

Greetings.....Mrs. L. S. Thompson

Message.....Mrs. Harold F. Wahlquist  
President, Woman's Auxiliary  
to American Medical Assn.  
Milwaukee, Wisconsin

Presentation of New Officers..Mrs. Clark Bailey  
Installation of Elected

Officers.....Mrs. Harold F. Wahlquist  
Inaugural Address.....Mrs. John S. Harter  
Announcements of Committee

Chairman.....Mrs. John S. Harter  
Final Report of

Registration.....Mrs. R. R. Slucher  
Adjournment

### Thursday, October 4

8:00 A. M.

### SUBSCRIPTION BREAKFAST

Post-Convention Board of Directors

Meeting.....Mrs. John Harter, President

### Thursday, October 4

7:00 P. M.

Crystal Ballroom

Annual Subscription Dinner of the Kentucky  
State Medical Association

### STATE CONVENTION COMMITTEES

General Chairman.....Mrs. John D. Gordinier  
Louisville

Registration.....Mrs. R. R. Slucher  
Buechel

Entertainment.....Mrs. George A. Sehlinger  
Chairman, Louisville  
Mrs. Glenn Bryant  
Co-Chairman, Louisville

Hospitality .....Mrs. U. Ray Ulferts  
Louisville

Publicity.....Mrs. J. Richard Gott  
Louisville

Exhibit.....Mrs. M. L. Barnes  
Chairman, Louisville  
Mrs. Walker Owens  
Mt. Vernon  
Mrs. Irving Gail  
Lexington

### PAST PRESIDENTS OF THE WOMAN'S AUXILIARY TO THE KENTUCKY STATE MEDICAL ASSOCIATION

- \*1923 Mrs. Graham Lawrence, Shelbyville
  - 1924 Mrs. Graham Lawrence, Shelbyville
  - \*1925 Mrs. V. A. Stilley, Benton
  - 1926 Mrs. V. A. Stilley, Benton
  - 1927 Mrs. William M. Martin, Harlan
  - \*1928 Mrs. J. T. Reddick, Paducah
  - 1929 Mrs. P. E. Blackerby, Louisville
  - 1930 Mrs. E. B. Houston, Murray
  - 1931 Mrs. George A. Hendon, Louisville
  - 1932 Mrs. A. T. McCormack, Louisville
  - 1933 Mrs. B. K. Menefee, Covington
  - \*1934 Mrs. Joseph I. Greenwell, New Haven
  - 1935 Mrs. Luther Bach, Florence
  - 1936 Mrs. E. A. Barnes, Albany
  - 1937 Mrs. Stephen C. McCoy, Louisville
  - 1938 Mrs. Harlan Usher, Sedalia
  - 1939 Mrs. Reasor T. Layman, Elizabethtown
  - 1940 Mrs. John M. Blades, Butler
  - 1941 Mrs. John G. South, Frankfort
  - 1942 Mrs. John B. Floyd, Richmond
  - 1943 Mrs. Octavus Dulaney, Louisville
  - 1944 Mrs. Eleanor Hume Offutt, Frankfort
  - 1945 Mrs. Shelby Carr, Richmond
  - 1946 Mrs. Elmer L. Henderson, Louisville
  - 1947 Mrs. Walker Owens, Mt. Vernon
  - 1949 Mrs. R. Haynes Barr, Owensboro
  - 1950 Mrs. Elbert W. Jackson, Paducah
- \* Deceased

**Steel allocations for hospital construction**  
were cut to 70,700 tons during the fourth quarter, about 30 per cent less than the 100,000 tons FSA Office of Civilian Health Requirements requested, the Washington office of the A.M.A. reports. FSA says it will appeal to Defense Production Administration if it has any real difficulty.

### New K. S. M. A. Members

Following is a list of new members whom the K.S.M.A. welcomes into the Association:  
JEFFERSON: I. Wilson Gettleman, Louisville; Andrew L. Hoekstra, Louisville; Edgar B. Morgan, Louisville; Mervin B. O'Neil, Louisville; A. S. Rosenstein, Louisville; John E. Ryan, Louisville; Leonard Singerman, Louisville; Richard C. Spear, Louisville.

## Centennial is Product of Two-Year Effort of Committee

Perhaps many of us have not realized the degree of responsibility the Centennial Committee has shouldered, or the amount of effort it has expended, in organizing the Centennial Celebration.

The Committee was organized at the Owensboro Meeting in 1949 and immediately went to work collecting material and ideas. Its first meeting was held early in 1950 and it has met any number of times since.

Because of somewhat limited resources, the Committee decided at the outset that it was best to do a few things well and to undertake only the most worthwhile objects. Long and careful consideration was given to the possible features before decisions were made.

When the projects were decided upon, each member of the Committee was assigned one or more features to develop. He was made chairman of a subcommittee with authority to appoint others to help him in the development of his plans. There is no way to fully estimate or appreciate the time and effort spent, or the number of miles traveled by this committee in behalf of the 100th Birthday Celebration of K. S. M. A.

We think a very accurate appraisal of this committee's contribution was made

recently when a veteran official of the K. S. M. A. was heard to comment, "No committee of the Association in my memory has met more often, worked harder and been more unsung than our Centennial Committee."

The members of the Centennial Committee are: Sam A. Overstreet, M. D., Chairman; Richard R. Slucher, M. D.; W. Clark Bailey, M. D.; William R. McCormack, M. D.; J. Duffy Hancock, M. D.; Emmet F. Horine, M. D.; R. Haynes Barr, M. D.

Other committees playing an important part in the Centennial Meeting are:

The Committee on Arrangements. Members are W. Clark Bailey, M. D., Chairman; Charles M. Edelen, M. D.; Charles F. Long, M. D.; B. J. Baute, M. D.; William H. Pennington, M. D.

The Committee on Scientific Exhibits. Members are E. L. Pirkey, M. D., Chairman; D. Woolfolk Barrow, M. D.; Harold Gordon, M. D.; Charles F. Wood, M. D.; Jesshill Love, M. D.

The Committee on Technical Exhibits. Members are Carlisle R. Petty, M. D., Chairman; J. Spalding Abell, Jr., M. D.; Clyde H. Foshee, M. D.; E. L. Shiflett, M. D.; Arthur T. Hurst, M. D.

The Centennial Golf Committee. Members are William C. Wolfe, M. D., Chairman; George W. Pedigo, M. D.; Leo W. Zimmerman, M. D.

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The Army has released 579 Medical Corps reservists since the start of the Korean War through July 31, according to the A.M.A. Washington office. In the same period it has called 3,331 reserve medical officers to active duty, including 1,691 Priority I physicians. Requests for release are based on the priority system, taking into account length of service, including combat duty, and the need for a particular physician's services.

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Information on physician distribution has been requested of all state governors by Senator James E. Murray, (D., Mont.) chairman of the Committee on Labor and Public Welfare. He informed them of a proposal to use federal subsidies to persuade doctors to move to areas where there is an acute shortage of medical personnel, and asked them to reply promptly to the questions as to whether they had too many doctors, not enough, or just about enough to meet the needs of their residents.

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Construction of a \$235,000 Academy of Medicine Library, which will also house offices, conference rooms and auditorium, has begun in Toledo, Ohio, and is expected to be completed by the summer of 1952, according to E. C. Mohr, M. D., chairman of the Board of Trustees of The Academy of Medicine of Toledo and Lucas County. The Academy has 467 members.

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Federal grants for "wheelchair" homes have been given to nearly 3,600 disabled veterans, reports Veterans Administration, by an Act of Congress in 1948, later amended, under which V-A defrays 50 per cent of the cost of such homes up to a maximum of \$10,000. Originally for paralyzed veterans only, the amended law makes eligible all veterans whose service-connected disabilities result in the loss, or loss of use, of both legs. Ramps, instead of steps, doorways wide enough to accommodate a wheelchair, and exercise rooms are some of the special features of these homes.



## THE CONTRIBUTION OF ALBAN G. SMITH, OF KENTUCKY, TO THE EARLY HISTORY OF SURGERY

James Willis Markham, M. D.\*

BALTIMORE, MD.

The role of Kentucky's early surgeons in pioneering the progress of surgery has been discussed frequently by medical historians (2, 5, 6, 14), and is widely appreciated. The contributions to surgery made by Kentuckians in the first part of the nineteenth century were products of a boldness, judgment and skill that amazes the long trained surgeons of today (13, 24, 29, 31).

Walter Brashear, of Bardstown, performed the first successful amputation at the hip joint in 1806 (3, 13); Ephraim McDowell, of Danville, did the first successful ovariectomy in 1809 (22); Charles McCreary, of Hartford, (the Dictionary of American Medical Biography (18) spells his name 'McCreery'; however, Gross (13) and most references use the spelling 'McCreary'), removed the entire clavicle for the first time in 1813 (21); and in 1819 Benjamin Dudley, of Lexington, became the first surgeon in America to trephine the skull for epilepsy with favorable results (7).

A contemporary of these surgical pioneers, and known to some of them, was Alban G. Smith (later known as Alban Goldsmith), of Danville. Smith's contribution to the early development of surgery is less well known and, in fact, does not appear to have received due credit in the past. Therefore it seemed worthwhile to review and reevaluate Smith's experience.

### The First Laminectomy

In 1829, when spinal surgery was attempted but rarely, Smith reported a case in which he removed the spinous processes and laminae for traumatic fracture of the spine with associated neurologic symptoms. Although this condition had been treated surgically prior to that time, Smith's case was the first known to have survived a formal laminectomy, an operation then regarded with utmost dread and attended by an exceedingly high mortality rate. Moreover, this was the second instance in which the operation had been performed in America.

The first laminectomy known to have been performed in America was done by J. R. Barton, of Philadelphia, in 1824. The patient had a traumatic fracture-dislocation of the spine and died on the second postoperative day. Barton did not report this case himself (1, pgs. 421-422).

Smith's article, which appeared in the North American Medical and Surgical Journal in July, 1829, began as follows: "About two years since, I was called a distance of about twelve miles, to a place called Pleasant Hill, the residence of a community of the people commonly called Shakers, to see a young gentleman, a member of the society, who had fallen from a horse, and had become paralyzed in all the extremities with the exception of the muscles above the elbow joint" (28).

No further details of the patient's condition were given, except that there was also numbness of the limbs and the general state of health was good. Believing the vertebrae to have been dislocated, as well as fractured, Smith declined to operate at that time, presuming the patient would die within a few weeks. Two years later he was consulted again by relatives of the patient, with news that Dr. Benjamin Dudley had been called in consultation recently. Dr. Dudley, after making an incision over the injured spinous processes, expressed his opinion there was no dislocation; but he did not attempt to remove any bone and was unwilling to do anything further.

### Description of Operation

In desperation the patient's relatives prevailed upon Smith to try anything that might help. His decision to operate seemed based largely on the new evidence that the case was one of simple fracture without dislocation. In writing of the operation, Smith said, "I made an incision five or six inches in length, along the spinal ridge, and then two deep incisions, transversely to, and at each extremity of the former, and three and a quarter in length, all down to the bone. I then dissected all the muscles and ligaments as far as the heads of the trans-

\*From the Division of Neurological Surgery, The Johns Hopkins Hospital, Baltimore, Md.

verse processes and scraped the bone clean. . . ."

He went on to say, "I next took a small Hey's saw, and made an incision on both sides as near the base of the transverse process as I could with safety to the spinal marrow and the nerve roots going off at the sides, and long enough to cut through the bone above, which was the third dorsal vertebra."

In considerable detail he described the method of removing the spinous processes of the second, third and fourth dorsal vertebrae and the lamina of the fourth, which was the one most severely injured. ". . . I now brought the parts together, putting a tent at the bottom, and put him to bed. He had a chill, succeeded by a fever, and some bilious symptoms, which were carried off by a dose of calomel."

### Prognosis of the Case

Smith's account of the patient's post-operative course, however, was meagre. One week later he observed, "The ulcers in the gluteal region . . . were healing up; and he had some additional sensation in his hands. You never saw a creature so overjoyed in your life. . . ." In his subsequent letter of May 7, 1829, Smith wrote, ". . . feeling has now got down into his thighs. . . ." but did not add anything more.

Although the dates of injury and operation were not given in Smith's article, Gross (13) stated that the accident occurred on March 31, 1827, and the operation on October 5, 1827. However, these dates do not agree with the conclusions one gains from reading Smith's paper, which began with the words, "About two years since I saw a young gentleman . . ." Smith went on to say he did not operate at that time and did not see the patient until "recently." An editorial footnote to the article, which was published in July, 1829, referred to a "subsequent letter" dated May 7, 1829, in which the hopeful followup note was given. This would suggest the first letter must have been written sometime earlier in 1829; and since several weeks elapsed between the date of operation and the writing of the first letter, this would seem to place the date of operation sometime early in 1829 or late in 1828, probably the latter. Had the operation been performed in 1827, as Gross said, and Smith waited until 1829 to write his article, it would seem unlikely he

would still have regarded the patient as showing signs of improvement. Moreover, Gross obtained his dates from a letter written to him by a neighbor of the patient on September 6, 1852, or twenty-four years after the incident, which would tend to place these dates under considerable doubt.

The letter written to Gross, nevertheless, provided the only additional bit of information about the long term operative result. It reveals the patient lived for nearly five years afterward. Although some degree of sensation was restored to the affected areas, useful function of the paralyzed muscles was not regained.

### Historical Significance

The historical significance of Smith's case lies in that it appears to have been the first successful laminectomy reported in the literature. An exhaustive review of the history of spinal surgery conducted recently by this writer (23) did not reveal any cases previous to that of Smith in which a formal laminectomy was done successfully. Only three instances could be found in the literature prior to 1829 in which significant operations on the spine were performed successfully, those of Ambroise Pare (25) in 1565, Geraud (10) in 1745 and Louis (20) in 1762. However, in each of these details of the extent and technique of the operative procedure were such that one could not with certainty determine that the laminae were actually removed and the spinal canal exposed.

### Early Surgery

Prior to 1814 laminectomy had been recommended as early as the seventh century by Paul of Aegina (26), and later by various writers such as Fabricius Hildanus (9, pgs. 34-36) in 1646, James (17) in 1745 and Heister (15) in 1750, and by others (30); but evidence that the operation had actually been performed, successfully or otherwise, is inconclusive.

### Work of Other Surgeons

In 1814, Cline (4) of London, resected the spinous processes and laminae for traumatic fracture-dislocation of the spine and since then has been accredited generally as being the first to carry out this procedure. (However, Cline's patient died on the second postoperative day. The case was not reported by him). Between 1814 and 1835 eight additional cases were operated upon (16, 19), but with the ex-



ception of Smith's all died of complications attributed to the operation and early in the postoperative period.

Although some writers on this subject were aware of Smith's experience (and apparently some were not) the importance of his case was minimized, if recognized at all. The basis for this appears to have been in part related to the incomplete followup material. Most writers have accredited Edwards (8) in 1838 as being the first to perform a laminectomy successfully, yet Edwards did not report his own case, and the only means by which it was recorded in the literature was a brief paragraph by Sir Charles Bell in a surgical review: "An operation of this kind has been done of late by Edwards, of Caerphilly, South Wales. The posterior arch of a lumbar vertebra was raised and the symptoms of compression relieved. I am informed the patient did well" (8, pg. 162). This was written within two to three months after the operation and does not give any more information, if as much, as Smith provided in his article. Moreover, one cannot be confident that Edwards actually removed all or part of a lamina, since the words "... the posterior arch of a lumbar vertebra was raised ..." do not necessarily suggest actual resection of bone.

It is unfortunate that Smith's article did not attract more interest and that he was not given due credit for his remarkable achievement. The condition under which the operation was performed must have been primitive and certainly without the benefit of general anesthesia, hospital equipment and other aids. Moreover Smith had little or no precedent to guide him, yet his achievement was far in advance of his time. For the next sixty years laminectomy was followed almost invariably by fatal complications, and the operation itself was not generally accepted for nearly seventy-five years later.

Biographical material concerning Alban G. Smith is scant. His name was changed to Alban Goldsmith by an act of the New York state legislature, probably some time after 1837 (18). He was born in 1788 (?), possibly in Maryland, and died in 1865 (?). It is known he was associated with Ephraim McDowell, first as an assistant, later as an associate; and it is believed he was present when McDowell did his celebrated ovariectomy in 1809. In 1823 Smith himself performed such an operation and

thus became the third in the United States to do a successful ovariectomy (18).

### Lecturer in Surgery

In 1833 he obtained a charter for the inauguration of the Louisville Medical Institute, which was opened in 1837, but he himself did not become associated with it. In 1833 he moved to Cincinnati where he accepted the chair in surgery in the Medical College of Ohio and remained there until 1837. He then went to New York where he was lecturer in surgery for two years at the College of Physicians and Surgeons of New York, the only medical school in the city at that time.

He remained in New York the rest of his life, practicing genito-urinary surgery. In this field he became well known in his time and wrote two treatises concerning that specialty (11, 12). While in Kentucky he developed his technique of lithotripsy and is said to have been one of the earliest in the United States to practice this procedure. His son, Middleton Goldsmith, was at one time professor of surgery in the Kentucky School of Medicine in Louisville, and later practiced in Vermont, where he became president of the Vermont State Medical Society in 1851 (27). Both father and son were particularly interested in ornithology.

This article is presented with the intention of clarifying the role of Alban G. Smith in the early development of surgery and to give credit for the first successful laminectomy to one of Kentucky's pioneer surgeons where it would seem properly to belong.

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## COMPARATIVE MORBIDITY OF EARLY AND LATE AMBULATION

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Early ambulation in surgical patients is not a new method of post-operative care. Actually it was practiced, perhaps inadvertently, by the Kentucky physician who performed the first ovariectomy in 1809. However, it has only recently been brought back into general use. Emil Reis<sup>1</sup> is credited with its renaissance in this country in 1891. But early ambulation has gained wide acceptance only since the early 1940's. Leithauser<sup>1</sup> did much to renew interest in the procedure.

### Definition

"Early ambulation" means getting the patient out of bed and walking, not sitting, as soon as practicable. When he can co-operate and his blood pressure and pulse rate have been stabilized, the right time has come to begin "early ambulation." This time varies, of course, with each individual. A patient who has had an in-

guinal hernia repaired using novocaine as a local anesthetic agent may walk back to his room after the operation, while a patient who has had a general anesthetic usually takes a few hours to become able to co-operate. Early ambulation is not merely getting a patient out of bed to sit in a chair beside the bed. To be effective it must be worked at by both the patient, the doctor, and especially the nursing staff in charge, and it must be walking.

### Effects in Five Systems

The effects of early ambulation may be studied by observing the changes, which may occur with its use in five systems of the patient: (1) the circulatory system; (2) the respiratory system; (3) the effect on wounds; (4) the system of elimination; (5) the economic system. This last may have little physiologic value but is an item of considerable interest to the vast majority of patients.



A great number of papers have been written in recent years about the various aspects of early ambulation. Although not all the benefits which were at first anticipated were actually realized there is almost universal agreement that enough were realized to make the procedure well worth while.

### Statistical Studies

It is the purpose of this paper to make a statistical study of the improvements, or drawbacks, if any, in morbidity and mortality in patients undergoing major surgery after early ambulation was started as a part of their post-operative treatment. Most of these cases were abdominal in nature and no chest surgery is included. For this purpose the patients in the last year before early ambulation was instituted were studied and compared to a similar study of patients in the three years following the start of early ambulation. In both groups the patients were consecutive except no patients under 20 years of age were included.

Early post-operative ambulation was started in January 1946. In the "pre-ambulatory" year of 1945 there were 526 patients available for study.

For purposes of contrast there were 1201 cases studied in the years of 1946, 1947 and 1948. All of these had major abdominal, radical mastectomy and goiter operations. The patients were divided into age groups by decades and further studied by operative procedures done. All patients over 60 years of age were grouped together. The incidence of pneumonia, atelectasis, wound infection, wound dehiscence, paralytic ileus, peritonitis, urinary cystitis, thrombophlebitis, pulmonary embolism, serum and hematoma in wound were ma-

jor causes of the morbidity and death rates.

In a recent report Jaergenson and Smith<sup>2</sup> report the incidence of wound dehiscence as being 0.245% and other reported rates vary from 0.2 to 2.0%, most reports ranging from 0.5% to 1.0%. Burch and Lovely<sup>3</sup> recently reported an incidence of atelectasis of 4.3%, cystitis 2.8%, pneumonia 1.4%, wound infection 0.3%, and thrombophlebitis 0.3% and a total morbidity incidence of 18.5%. These values were found in 228 cases of total abdominal hysterectomy. Finn<sup>4</sup> reports a mortality rate of 0.42% in gynecological operations done on 17,665 patients. Trice<sup>5</sup> has reported no cases of thrombophlebitis in a series of 562 general surgical cases and quotes Leithauser as having had only four cases of thrombophlebitis in 3,703 cases of hernia operations. The report of Trice is certainly a surprisingly low incidence as it has been estimated<sup>6</sup> that between 50 and 60% of all adults carry thrombi in the plantar veins or veins of the calf muscles and about 10% of thrombophlebitis occurs in patients in apparent good health and fully ambulatory.

### Pre-Early Ambulation

In the following tables the "pre-early ambulation" cases will be designated as the control cases and the ambulatory cases will be designated as ambulatory:

In this age group the total morbidity in the ambulatory patients is only one-third that of the control group, most of the difference being in the reduction in post-operative pneumonia and urinary cystitis. Even in this relatively young age group, however, it will be noticed that there was one non-fatal pulmonary embolus in the ambulatory group.

TABLE I—AGE GROUP 20-29

Control—90 Cases			Ambulatory—167 Cases		
Complication	No.	% Morbidity	No.	% Morbidity	
Pneumonia .....	2	2.2	0	0.0	
Atelectasis .....	1	1.1	2	1.2	
Wound dehiscence .....	0	0.0	0	0.0	
Wound infection .....	2	2.2	1	0.6	
Ileus .....	0	0.0	0	0.0	
Peritonitis .....	0	0.0	0	0.0	
Serum in wound.....	2	2.2	0	0.0	
Urinary cystitis .....	2	2.2	0	0.0	
Thrombophlebitis .....	0	0.0	1	0.6	
Pulmonary embolism ..	0	0.0	1	0.6	
Deaths .....	0	0.0	0	0.0	
Total morbidity .....	9	10.0	5	2.9	

TABLE II—AGE GROUP 30-39

Control—116 Cases			Ambulatory—302 Cases		
Complication	No.	% Morbidity	No.	% Morbidity	
Pneumonia .....	2	1.7	2	0.66	
Atelectasis .....	4	3.4	2	0.66	
Wound infection .....	4	3.4	2	0.66	
Wound dehiscence .....	1	0.8	1	0.33	
Ileus .....	1	0.8	1	0.33	
Peritonitis .....	1	0.8	2	0.66	
Serum in wound .....	0	0.0	3	0.99	
Cystitis .....	2	1.7	3	0.99	
Thrombophlebitis .....	1	0.8	3	0.99	
Pulmonary embolus ....	0	0.0	2	0.66	
Deaths .....	1	0.8	4	1.32	
Morbidity .....	17	14.6	25	8.2	

TABLE III—AGE GROUP 40-49

Control—146 Cases			Ambulatory—315 Cases		
Complication	No.	% Morbidity	No.	% Morbidity	
Pneumonia .....	3	2.0	1	0.31	
Atelectasis .....	2	1.4	3	0.9	
Wound infection .....	7	4.8	3	0.9	
Wound dehiscence .....	0	0.0	1	0.31	
Ileus .....	0	0.0	1	0.31	
Peritonitis .....	3	2.0	3	0.9	
Serum .....	0	0.0	2	0.62	
Cystitis .....	3	2.0	1	0.31	
Thrombophlebitis .....	2	1.4	6	1.8	
Pulmonary embolus ....	1	0.7	2	0.62	
Deaths .....	0	0	6	1.8	
Morbidity .....	21	14.3	29	9.2	

In Table II there is again evidence of apparent reduction in morbidity from pulmonary complications. Again there are no pulmonary emboli in the control group but two emboli in the ambulatory group. The death in the control group was due to inanition from a gastrojejuno-colic fistula while deaths in the ambulatory group were due to cardiac arrest during operation in one, pulmonary embolus in one, and two were due to uremia secondary to widespread carcinoma of the ovary. The total morbidity in the ambulatory group is only slightly more than half that of the control group. The cardiac arrest case should not be counted in early ambulation but was included to keep the series unbroken.

In Table III again we see the reduction in pulmonary complications in the ambulatory group. There also is a greater incidence in thrombo embolic disease in the ambulatory group than in the control group. The cause of the relatively large incidence of wound infection in the control group is obscure and no plausible explanation could be found. Deaths in the

ambulatory group were due to acute yellow atrophy of liver in one; pulmonary embolus, one; secondary shock following colostomy for gunshot wound of colon, one; asphyxia from aspiration of vomitus, uremia from carcinoma of ovary and congestive heart failure, one each. Four of these deaths could be classed as preventable and the death from shock and from aspiration of vomitus should again not be counted against early ambulation but were counted for the reason given above.

In the age group in Table IV there is still a significant reduction in pulmonary complications but not as great as in the previous groups. Again thrombo-embolism is a greater threat in the ambulatory group than in the control group but total morbidity is again only slightly more than one-half that of the control group. The death rate is also only one-half that of the control group. Deaths in the ambulatory group were due to coronary artery thrombosis in two cases, pulmonary emboli in two cases, uremia in two cases, generalized peritonitis from ruptured colonic diverticulum in one case and in-



anition in one case. The actual cause of death in one case was undetermined but thought to be due to progressive thrombosis of cerebral arteries.

There is a very significant reduction in the pulmonary complications in the ambulatory group of patients over 60 years of age, an age when pulmonary complications are perhaps most prevalent and certainly most serious as to prognosis. However, there is still the increased incidence of thromboembolic disease in the ambulatory group. The difference in morbidity between the two groups is less than in the younger age groups but still very heavily in favor of ambulation. Urinary cystitis is also reduced in the ambulatory group. This is significant because the urinary troubles in this age group are so prevalent and disabling, especially in the males.

Cause of death in this group was pulmonary embolus in four, shock in two. One of these followed dehiscence of the wound and the other died the day of operation and did not live long enough for

early ambulation. Peritonitis caused two deaths, one from a ruptured gallbladder, uremia caused two deaths, two were cardiac in origin and one from the so-called hepato-renal syndrome. One death from widespread metastatic carcinoma from colon and cause of death in one was not determined. It is believed that none of these deaths were caused by or directly attributable to the practice of early ambulation although 90% of them should probably be classed as preventable. All deaths from pulmonary emboli should be in the preventable class.

Morbidity Studies

The morbidity in these same patients was studied by the type of operation used. The following tables show the nature of each operation and the number subjected to these procedures. There were 419 females and 109 males in the control group and there were 946 females and 255 males in the ambulatory group. The next table (VI) shows the results of the study of complications in appendectomies done in the two groups.

TABLE IV—AGE GROUP 50-59

Control—80 Cases			Ambulatory—229 Cases		
Complication	No.	% Morbidity	No.	% Morbidity	
Pneumonia .....	2	2.5	3	1.3	
Atelectasis .....	2	2.5	7	3.1	
Wound infection .....	3	3.7	4	1.7	
Wound dehiscence .....	0	0.0	0	0.0	
Ileus .....	1	1.2	1	0.4	
Pulmonary edema .....	2	2.5	0	0.0	
Peritonitis .....	0	0.0	1	0.4	
Serum .....	0	0.0	1	0.4	
Cystitis .....	0	0.0	3	1.3	
Thrombophlebitis .....	1	1.2	5	2.1	
Pulmonary embolus ....	2	2.5	3	1.3	
Deaths .....	7	8.7	9	3.9	
Morbidity .....	20	25.0	37	16.1	

TABLE V—AGE GROUP 60 and Over

Control—90 Cases			Ambulatory—188 Cases		
Complication	No.	% Morbidity	No.	% Morbidity	
Pneumonia .....	5	5.3	0	0.0	
Atelectasis .....	2	2.1	2	1.06	
Wound infection .....	4	4.2	3	1.6	
Wound dehiscence .....	1	1.05	3	1.6	
Ileus .....	0	0.0	2	1.06	
Peritonitis .....	1	1.05	2	1.06	
Serum .....	5	5.3	5	2.5	
Cystitis .....	2	2.1	2	1.06	
Thrombophlebitis .....	0	0.0	8	4.2	
Pulmonary embolus ....	2	2.1	3	1.5	
Deaths .....	6	6.3	15	7.9	
Morbidity .....	28	29.7	45	23.8	

TABLE VI—APPENDECTOMIES

Control—65 Cases			Ambulatory—145 Cases		
Complication	No.	% Morbidity	No.	% Morbidity	
Pneumonia .....	3	4.6	0	0.0	
Atelectasis .....	2	3.07	0	0.0	
Wound infection .....	1	1.5	4	2.7	
Serum .....	1	1.5	0	0.0	
Wound dehiscence .....	0	0.0	2	1.3	
Ileus .....	0	0.0	1	0.68	
Cystitis .....	1	1.5	1	0.68	
Thrombophlebitis .....	0	0.0	0	0.0	
Pulmonary embolus .....	0	0.0	0	0.0	
Peritonitis .....	0	0.0	0	0.0	
Deaths .....	0	0.0	0	0.0	
Morbidity .....	8	12.3	8	5.52	

TABLE VII—VENTRAL HERNIA

Control—8 Cases			Ambulatory—57 Cases		
Complication	No.	% Morbidity	No.	% Morbidity	
Pneumonia .....	1	12.5	0	0.0	
Atelectasis .....	0	0.0	0	0.0	
Wound infection .....	0	0.0	0	0.0	
Wound dehiscence .....	0	0.0	1	1.7	
Ileus .....	0	0.0	0	0.0	
Peritonitis .....	0	0.0	0	0.0	
Cystitis .....	0	0.0	1	1.7	
Thrombophlebitis .....	0	0.0	0	0.0	
Pulmonary embolus .....	0	0.0	2	3.5	
Recurrence .....	0	0.0	5	8.7	
Deaths .....	1	12.5	2	3.5	
Morbidity .....	2	25.0	11	19.2	

Pneumonia and atelectasis were entirely eliminated in the ambulatory group. Wound infection in the ambulatory group is almost twice that of the control group. It may be noticed that no cases classified as peritonitis are included in either group. Several of the patients in each group had perforated appendices but none of these became generalized peritonitis which is certainly a tribute to the effect of antibiotics. The morbidity in the ambulatory group is about one-half that of the control group. There were two instances of dehiscence in the ambulatory group and both of these were associated with those cases in which wound infection occurred. Both of these cases also had drains in the wound. There were no deaths in either group.

In Table VII the control group is not large enough to make any effective comparison. But there was a recurrence rate in the ambulatory group of 8.7%. Also there was a very high rate of pulmonary emboli in the ambulatory group. There is not an adequate number of cases to make comparison of morbidity rates of any value.

It seems to indicate that bed exercises instead of "early ambulation" would be safer for patients whose ventral hernias have been repaired. An incidence of five recurrences in 57 patients cannot be "brushed off"; four of the five recurrences occurred in two patients.

In Table VIII one of the deaths in the ambulatory group was due to a pulmonary embolus and one was due to a coronary artery accident. Both femoral and inguinal hernia cases were included here. The death from embolus was in a femoral hernia which required resection of small bowel. This patient also had advanced pulmonary tuberculosis and also carcinoma of the stomach which was inoperable and which had both pelvis and pulmonary metastases. She died the day of operation. The great majority of both the control and ambulatory groups were operated on with the use of local anesthesia.

In Table IX pneumonia is eliminated in the ambulatory group and the incidence of atelectasis is nearly eliminated. Thrombophlebitis is markedly increased over the control group and the incidence of total



TABLE VIII—GROIN HERNIA

Control—35 Cases			Ambulatory—87 Cases		
Complication	No.	% Morbidity	No.	% Morbidity	
Pneumonia .....	0	0.0	0	0.0	
Atelectasis .....	0	0.0	1	1.1	
Wound infection .....	1	2.8	0	0.0	
Cystitis .....	0	0.0	0	0.0	
Peritonitis .....	0	0.0	0	0.0	
Serum .....	0	0.0	2	2.2	
Ileum .....	0	0.0	0	0.0	
Thrombophlebitis .....	0	0.0	0	0.0	
Pulmonary embolus ....	0	0.0	1	1.1	
Deaths .....	0	0.0	2	2.2	
Morbidity .....	1	2.8	6	6.6	

TABLE IX—COLON

Control—21 Cases			Ambulatory—35 Cases		
Complication	No.	% Morbidity	No.	% Morbidity	
Pneumonia .....	3	14.2	0	0	
Atelectasis .....	2	9.5	1	2.8	
Wound infection .....	1	4.7	2	5.7	
Wound dehiscence .....	1	4.7	1	2.8	
Peritonitis .....	0	0.0	1	2.8	
Cystitis .....	0	0.0	2	5.7	
Thrombophlebitis .....	0	0.0	4	11.4	
Pulmonary embolus ....	0	0.0	1	2.8	
Deaths .....	1	4.7	4	11.4	
Morbidity .....	8	38.0	16	45.7	

TABLE X—STOMACH AND DUODENUM

Control—27 Cases			Ambulatory—86 Cases		
Complication	No.	% Morbidity	No.	% Morbidity	
Pneumonia .....	1	3.7	0	0.0	
Atelectasis .....	2	7.4	2	2.3	
Wound infection .....	0	0.0	0	0.0	
Wound dehiscence .....	1	3.7	1	1.1	
Peritonitis .....	0	0.0	3	3.4	
Cystitis .....	0	0.0	0	0.0	
Thrombophlebitis .....	0	0.0	0	0.0	
Pulmonary embolus ....	1	3.7	3	3.4	
Cerebral accident .....	1	3.7	0	0.0	
Effusion chest .....	0	0.0	1	1.1	
Deaths .....	1	3.7	5	5.8	
Total morbidity .....	7	25.9	15	17.4	

TABLE XI—BILIARY SYSTEM

Control—60 Cases			Ambulatory—136 Cases		
Complication	No.	% Morbidity	No.	% Morbidity	
Pneumonia .....	4	6.6	2	1.4	
Atelectasis .....	2	3.3	5	3.6	
Wound infection .....	2	3.3	3	2.2	
Wound dehiscence .....	0	0.0	0	0.0	
Peritonitis .....	1	1.6	3	2.2	
Cystitis .....	0	0.0	1	0.72	
Ileus .....	2	3.3	0	0.0	
Thrombophlebitis .....	3	5.0	2	1.4	
Pulmonary embolus ....	1	1.6	3	2.2	
Deaths .....	5	8.3	6	4.4	
Morbidity .....	20	33.3	25	18.3	

TABLE XII—GYNECOLOGY

Control 209 Cases			Ambulatory—467 Cases		
Complication	No.	% Morbidity	No.	% Morbidity	
Pneumonia .....	3	1.4	2	0.42	
Atelectasis .....	2	0.9	4	0.85	
Wound infection .....	2	0.9	2	0.42	
Wound dehiscense .....	0	0.0	1	0.21	
Peritonitis .....	3	1.4	4	0.85	
Cystitis .....	7	3.34	9	1.9	
Ileus .....	1	0.04	2	0.42	
Thrombophlebitis .....	0	0.0	9	1.9	
Pulmonary embolus ....	1	0.4	2	0.42	
Vesico-vag. fistula ....	0	0.0	1	0.21	
Deaths .....	2	0.9	4	0.85	
Morbidity .....	21	10.05	40	8.5	

TABLE XIII—DAYS IN HOSPITAL

PRE-AMBULATORY	AMBULATORY
1945	1946, '47, '48
No. 6,279	No. 12,670
Avg. 11.9	Avg. 10.5

morbidity is increased, principally due to the venous thrombosis and increased cystitis. The death rate is also slightly more than twice as great as the control group, principally due to three of these patients having widespread metastases at the time of operation for colonic obstruction.

In Table X the pulmonary complications are greatly reduced in the ambulatory group although the incidence of pulmonary emboli are about the same. It will be noticed in many of the tables that there is a disproportion of pulmonary emboli as compared to thrombophlebitis. The authors recognize that most emboli to the chest come from the veins of the lower extremities but also most of the emboli come from phlebothrombosis rather than thrombophlebitis. The total morbidity in the ambulatory group is only two-thirds that of the control group. Peritonitis in the ambulatory group is increased due in the greater part to a blowout of the duodenal stump in two cases. Both of these cases survived.

Table XI: In operations on the biliary system pneumonia is reduced in the ambulatory group, while the incidence in atelectasis is similar in the two groups. Peritonitis is increased in the ambulatory group. Pulmonary emboli are increased in the ambulatory group. The death rate is about one-half that of the control group. Total morbidity is decreased almost one-half in the ambulatory group.

In gynecological operations there is some reduction in the incidence of pneu-

monia but very little change in the incidence of atelectasis. There is no significant difference in the incidence of cystitis in the ambulatory group. There is no difference in the occurrence of pulmonary emboli. Death rate is essentially the same in both groups. There is a slight reduction in total morbidity in the ambulatory group as compared to the control group. The vesico-vaginal fistula in one case should not be blamed on early ambulation. This fistula healed spontaneously under conservative management.

This study by operations does not include 28 breast operations, 32 goitre operations and 41 miscellaneous operations done in 1945. In the ambulatory group there were 192 cases which were not included in the statistical study by operations.

In 1945 the total post-operative days spent in the hospital were 6,279, an average of 11.9 days each. In the ambulatory group there were a total of 12,670 post-operative days, an average of 10.5 each. This represents a saving of 1.4 days in the hospital. This is a considerable saving for the individual patient.

A summary of the total morbidity in the two groups is shown in Table XIV, which is a summary of Tables I to V inclusive.

A study of the total morbidity shows a significant over-all reduction in pulmonary complications. There are about one-third the pulmonary complications in the ambulatory group as compared to the control group. Pneumonia is reduced by



a ratio of 1 to 5; atelectasis by  $\frac{1}{2}$ . There is no significant change in the incidence of wound dehiscence which indicates that early ambulation has no deleterious effect on wound healing when tissues are accurately approximated. Peritonitis is reduced by about one-third but this may at least in part be attributed to the use of the newer antibiotics. There is also a reduction in the incidence of wound infection which also may be explained as above. There is no apparent difference in the incidence of paralytic ileus. However, peristalsis became active much earlier in the ambulatory than in the control group. There is some reduction in the incidence of serum or hematoma in the wound. This indicates that early mobilization does not cause an increase in oozing in freshly incised wounds when hemostasis is adequate. There is a smaller incidence of cystitis in the ambulatory group but this does not accurately or adequately demonstrate the very gratifying, both to the doctor and patient, fewer catheterizations and decreased lapse of time before voiding occurred in the ambulatory patients. There is about twice the incidence of thrombophlebitis in the ambulatory group as in the control group. Part of this increase may be due to greater diligence in searching for mini-

mal cases of thrombophlebitis in the more recent cases. But there is no significant change in the incidence of pulmonary emboli. There has been and still are a great number of articles appearing in the literature which infer that early ambulation, alone, greatly reduces thrombo-embolic disease. This assertion, sadly, is certainly not borne out from this study. It is believed by the authors that deep venous thrombosis has its beginning on the operating table, or even in the pre-operative period in the more seriously ill patients, so that early ambulation has little chance to prevent this very distressing and frequently fatal complication. The incidence of thrombophlebitis in these cases is over twice as great in the ambulatory group as in the control group. The death rate from pulmonary embolus has been reduced by almost one-half in the ambulatory group but this was probably due to greater diligence in prevention of emboli after venous thrombosis had occurred rather than any benefit derived from early ambulation. Dr. Ochsner's work with Alpha tocopherol is very promising but even yet the problem is still present. Should we submit all patients to this treatment? If all surgical patients receive this therapy, the drug bill will be increased in a large number of patients treated needlessly.

TABLE XIV—SUMMARY

Control—526 Cases			Ambulatory—1201 Cases		
Complication	No.	% Morbidity	No.	% Morbidity	
Pneumonia .....	14	2.6	6	0.49	
Atelectasis .....	11	2.09	16	1.3	
Pulmonary edema .....	2	0.38	0	0.0	
Wound infection .....	20	3.8	13	1.8	
Wound dehiscence .....	2	0.38	5	0.41	
Ileus .....	2	0.38	5	0.41	
Peritonitis .....	5	0.94	8	0.66	
Serum .....	7	1.3	11	0.91	
Cystitis .....	9	1.7	9	0.74	
Thrombophlebitis .....	4	0.75	23	1.9	
Pulmonary embolus .....	5	0.94	11	0.91	
Deaths .....	14	2.6	34	2.3	
Morbidity .....	95	18.06	141	11.7	
Total pulmonary .....	32	6.08	33	2.7	
Pul. embolus deaths....	4	0.75	8	0.45	

TABLE XV

Cases	Abd. Hyster.		Upper Abd. Oper.	
	No.	%	No.	%
Thrombophlebitis	8	1.81	19	6.07
Pul. embolism	3	0.68	9	2.8
Deaths pul. emb.	1	0.22	5	0.59

There is very little change in the death rate between the two groups but the total morbidity rate is significantly reduced. It is believed that the greater part of this reduction can be primarily attributed to the use of early post-operative ambulation.

### Conclusions

1. Thrombophlebitis has not been reduced by the use of early ambulation. The hope that thrombo-embolic complication would be reduced was one of the main reasons early ambulation was started by the authors. This hope has obviously not been realized. However, the percentage of deaths due to pulmonary emboli in comparison to the total deaths shows a considerable reduction in the ambulatory group, these percentages being 28.5 in the control and 11.7 in the ambulatory group. As stated before, most, if not all, of this reduction can be attributed to prevention of pulmonary emboli in a greater number of patients. In studying these one other seeming contradiction to many reports in the literature was discovered. Many of these reports infer that thromboembolic disease has greater incidence in gynecological and other operations in the pelvic area than in operations involving the upper abdomen.

(See Table XV)

Combining these two series of cases we have a total of 441 cases of hysterectomy. Of these there were eight cases of thromboembolic complications. Three of these eight had pulmonary emboli and one of these three died of the embolus. There were 313 operations requiring an incision above the umbilicus. Nineteen of these had thromboembolic complications; nine had pulmonary emboli with five deaths. This is an incidence of 6.07% for deep venous thrombosis; 2.8% for pulmonary emboli and 0.59% death rate. In the hysterectomy cases these incidences are 1.81%, 0.68% and 0.22% respectively. Probably the greater factors in these results are the greater average age and the restricted pulmonary expansion in the cases involving upper abdominal operations and many of the patients in the older age groups had been at bed rest for varying periods before operation. Every effort is being made to have pre-operative as well as post-operative ambulation.

2. Pulmonary complications are reduced to a gratifying extent by the use of early ambulation. Pneumonia has been re-

duced by 2% and atelectasis by 1%. The total reduction in pulmonary complications is about 3.3%. If there were no other reasons this would be indication enough for the practice of early ambulation. This is especially true of the older age groups.

3. Cystitis has been reduced by about one-half. This reduction is most marked in the pelvic operative procedures. The elapsed time before spontaneous voiding occurs is greatly reduced in the ambulatory cases. The same may be said about the onset of active peristalsis and spontaneous active elimination of flatus. The incidence of troublesome paralytic ileus was not changed.

4. The incidence of wound dehiscence showed no change between the two groups. Most reports in the literature show little, if any, change in the rate of fibroplasia and wound healing when experiments are conducted on laboratory animals, some of which are active and others kept inactive.

5. The incidence of generalized peritonitis is little changed by ambulation and the reduction of 0.28% in this study can probably be accounted for by the use of antibiotics in those cases in which it was feared pre-operative or operative contamination had occurred.

6. Total morbidity. The total morbidity has been reduced by 5.4% which is certainly significant. Most of this is accounted for in the reduction of pulmonary complications.

7. Death rate. The total death rate was not significantly changed.

8. Miscellaneous. The abstract but nonetheless very important psychological outlook of the patients treated by early ambulation is of very great value. These patients very soon obtain confidence in their future welfare. They need fewer narcotics and their general discomfort does not last nearly as long. They very quickly become able to care for themselves to a great extent, thereby releasing the short-handed and overworked nursing staff for other duties. Strength is regained quickly and the hospital stay is reduced.

### Summary

1. A comparison has been made of the morbidity rate of patients before and after the introduction of early ambulation as part of their post-operative treatment.

2. A study of the major post-operative



complications both by age groups and by operative procedures done has been presented. This study was made from 1727 consecutive private patients who had had major abdominal, radical breast, or goiter operations. Patients less than 20 years of age were omitted from the study.

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## RENAL DISEASE IN RELATION TO HYPERTENSION

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individuals with renal disease as he found

Blood pressure in normal individuals is ordinarily maintained at a relatively constant level even though the range of variation is fairly wide. This level is influenced by many factors such as emotions, eating, posture, sleeping, exercise, body build, weight, fever, and climate. Blood pressure level rises gradually till the age of puberty and then the systolic, mean and pulse pressure rises gradually until the individual reaches the age of 60 and after this age rises rapidly. However the diastolic pressure in normal individuals does not change appreciably after puberty.

#### Incidence

What is the incidence of hypertension in practice? Dr. William Braasch<sup>1</sup> in 1940 recorded the results of a study of 975 cases taken at random from the registrations at Mayo Clinic and found that of 606 patients below the age of 50 only 9.1% had hypertension where as 369 patients over the age of 50 (37.9%) had hypertension. Thus the incidence of hypertension for the entire group of 975 patients with all types of disease was 20%.

One might wonder about the incidence of hypertension in a urological practice. Braasch<sup>1</sup> studied the incidence of hypertension in a group of 1684 patients who were subjected to renal surgical procedures at the Mayo Clinic because of various renal lesions. The incidence of hypertension in these patients was 18.7% which is about the same in this group of

for those patients with all types of disease. However it should be pointed out that in certain types of renal involvement the incidence of hypertension is well above the average and this is particularly noted in atrophic pyelonephritis where the incidence of hypertension is 46.5%.

#### Prevalence

Since arterial hypertension is so common and because so many different conditions may cause or be associated with elevated blood pressure one should keep in mind a good classification for hypertension. This is particularly important in view of the fact that certain cases of hypertension can be cured if properly diagnosed. The following classification is quoted from Page and Corcorans text on Arterial Hypertension.

#### Classification of Hypertension

##### RENAL

##### A. Affections of vessels

Arteriosclerosis  
Arteritis  
Panarteritis Nodosa  
Visceral lupus erythematosus  
Vascular anomalies and obstructions (embolism, venous or arterial thrombosis, aneurysm tumor)

##### B. Affections of parenchyma

Acute nephritis  
Chronic nephritis  
Pyelonephritis  
Hydronephrosis  
Polycystic disease  
Amyloidosis  
Infarcts  
Tumors

<sup>1</sup>Read at the All Service Conference of the University of Louisville School of Medicine, January 13, 1951.

- Hypernephroma
- Ectopia
- Toxemia of pregnancy
- X-ray lesions
- Renal stones
- Hypogenesis
- Dystopia
- C. Affections of perinephric structures
  - Perinephritis
  - Tumors
  - Hematoma
  - Retroperitoneal masses causing pressure on parenchyma
  - Wilms' tumor
- D. Affections of ureter
  - Obstruction (pelvis, ureter, pyelitis prostate, urethra)
- CEREBRAL
  - Increased intracranial pressure (trauma, tumor inflammation)
  - Diencephalic stimulation\*
  - Anxiety states
  - Lesions of brain stem (ascending paralysis, poliomyelitis)
  - Acute porphyria
- CARDIOVASCULAR
  - Heart failure
  - Arteriovenous fistula
  - Heart block
  - Coarctation of aorta\*
  - Polycythemia\*
  - Atheromatosis
- ENDOCRINE
  - Pheochromocytoma\*
  - Adrenal carcinoma\*
  - Adrenal hyperplasia (?)
  - Chorionepithelioma\*
  - Adrenal-like ovarian tumor
  - Cushing's syndrome\*
  - Pituitary basophilism (?)
  - Acromegaly
  - Thymic carcinoma\*
  - Hyperthyroidism\*
  - Arrhenoblastoma\*
  - Desoxycorticosterone\*
- UNKNOWN
  - Essential hypertension
  - Malignant hypertension

### Renal Basis

In this discussion, attention will be directed mainly to the first group where the etiology of the hypertension is on a renal basis. I have placed an asterisk beside each of the causes of hypertension other than renal for which a cure is known because it is self-evident that these should most certainly not be left undiagnosed. Unfortunately about 90-95% of the pa-

tients with arterial hypertension have "Essential" hypertension or hypertension of unknown cause and since this group is seen so commonly by the physician he becomes lulled into a lackadaisical state of mind and occupies himself almost entirely with the height of the blood pressure level and fails to make a careful and searching investigation into the cause of the hypertension.

In spite of the fact that the great bulk of hypertension is of unknown etiology, disease of the kidneys may induce hypertension. On the other hand it is also felt that regardless of the cause hypertension in itself tends to induce disease in the small vessels in various areas of the body particularly the renal arterioles and small arteries. A large proportion of the cases of advanced renal disease in patients over the age of 40 results directly from hypertension but only a few cases of hypertension result from primary renal disease. Once the hypertension has been established it aggravates the renal vascular lesions and then the renal disease in turn may aggravate the hypertension which in turn may lead to further renal damage. When this process proceeds at a slow rate the term benign nephrosclerosis is used but if this vicious cycle proceeds at a quite rapid rate the condition is called malignant hypertension or malignant nephrosclerosis. These terms refer to the rate of progression and not the underlying cause and consequently a patient with primary renal disease and secondary hypertension or a patient with primary hypertension and secondary renal disease may develop malignant nephrosclerosis or malignant hypertension. One may liken this situation to acute yellow atrophy and cirrhosis where the process in these two conditions is likewise similar but proceeding at different rates.

### Glomerulonephritis

Glomerulonephritis at some stage of the disease whether it be in the acute or chronic stage is almost always accompanied by hypertension although during the nephrotic stage hypertension may be either absent or of little significance but as the disease progresses and the edema recedes the blood pressure may rise quite rapidly and quite high. The renal functional pattern is one of reduction of glomerular filtration usually far below the level seen in malignant hypertension and differentiation of these two entities is aided by function studies plus the



demonstration of comparatively mild degrees of heart and brain vessel involvement. This is a necessary differentiation because proper treatment of chronic glomerulonephritis may bring about a remission at this state for a long period of time.

### **Pyelonephritis**

Pyelonephritis is much more common than is generally appreciated. According to some figures 75% of the cases of urinary tract stasis and infection, particularly in children, is the result of congenital malformations. The urinary tract may be obstructed by calculus, foreign body, neoplasm, inflammatory swelling or even physiologic obstruction such as cord, bladder and secondary urinary tract infection may then cause pyelonephritis to develop.

Pyelonephritis may be unilateral or bilateral and when it is bilateral it is most common to find an asymmetry in involvement of the two kidneys. This is an important point of differential diagnosis. Terminally glomerulonephritis and pyelonephritis may be exceedingly difficult to differentiate microscopically but the finding of asymmetry of involvement is characteristic of the latter disease. In the early stages of pyelonephritis the presence of numerous leukocytes and bacteria in the urine may be outstanding but in the later stages the kidneys become contracted and scarred and the usual methods of examination fail to reveal anything other than the findings commonly observed in glomerulonephritis or nephrosclerosis.

In females under the age of 35 chronic pyelonephritis is probably the most common cause of hypertension. Diagnosis of chronic pyelonephritis is not easy because the course of pyelonephritis is quite variable. The disease may remain essentially silent for many years and be discovered as an incidental finding at autopsy, and this is more likely to be true if the disease is unilateral.

In some patients the renal disease is likely to produce rapidly progressive hypertension which in turn produces damaged renal arterioles which in turn causes further hypertension and so on till the typical picture of malignant nephrosclerosis is present.

### **Treatment**

In the treatment of pyelonephritis eradication of the infecting organism with an all out effort employing appropriate antibacterial and anti-biotic agents as well as

operative procedure for the relief of the obstruction to the urinary tract is essential. Half hearted use of antibiotics may be worse than not using these agents at all because of the possibility of the development of resistant strains. The appropriate agent should be given in full dosage from the outset. When the disease is entirely unilateral and when the renal function tests indicate that the diseased kidney has completely lost its excretory function nephrectomy may be indicated provided the opposite kidney has normal function. Under such circumstances hypertension may be relieved. However, when both kidneys are involved the hypertensive process is rarely alleviated and may even be aggravated.

### **Unilateral Renal Disease**

Schwartz<sup>2</sup> in 1924 and Ask-Upmark<sup>3</sup> in 1929 described cases of hypertension in which only one kidney was found to be diseased at autopsy. However in 1923 Quimby<sup>4</sup> and in 1927 Crabtree<sup>5</sup> recorded cases in which nephrectomy that had been performed for a urological disorder was followed by a cure of the accompanying hypertension. The experimental work of Goldblatt<sup>6</sup> in 1934 focused attention on the role of unilateral renal lesions in hypertension and following this a large number of cases of nephrectomy for hypertension have been published and several good reviews have been written. Before discussing the clinical aspects of unilateral renal disease in relation to hypertension, however, a word or two should be mentioned about the experimental aspects.

### **Experimental Aspects**

Patton<sup>7</sup> et al in 1943 presented the collected results of nephrectomy on the experimental hypertension in rats. They noted that for the total series of 118 rats with experimental hypertension the blood pressure returned to normal in about 29% of the rats. It might be well at this point to mention the case report of Angus MacKay<sup>8</sup>, concerning his patient who had mild right hydronephrosis and a renal calculus. The stone was removed and three weeks later the patient developed hypertension with papilledema convulsions and periods of stupor. Nephrectomy was performed and a fibrous hull was found to be encasing the kidney. This was removed with the kidney and following the operation the blood pressure fell from 200/140 to normal where it remained during the years follow up study. This case deserves mention because of the similarity between it

and the cellophane bag induced hypertension in rats.

Patton<sup>7</sup>, et al, also demonstrated as did Wilson and Byrom<sup>9</sup> that although the height of the hypertension had very little to do with the results of nephrectomy the duration definitely influenced the results to be expected from nephrectomy. They noted that the blood pressure in 10 to 21 hypertensive rats returned to normal when hypertension had existed only 5-10 weeks. When hypertension had persisted for 11-45 weeks only 2 of 26 hypertensive rats had a return of their blood pressure to normal. It might be well to point out here that two weeks in the life of a rat is comparable to 1 year in a man. The rat, sheep and goat are the only known species except man in which unilateral renal damage may result in permanent hypertension. Unlike dogs, monkeys, and rabbits in which unilateral renal ischemia produce only a transient hypertension, the rat maintains it for over half his usual life expectancy. Patton<sup>7</sup> et al also reported 233 cases of patients who had undergone nephrectomy for hypertension. Thirty per cent of these patients had a return to normal of their blood pressure which was almost identical with the percentage found for experimental hypertension in the rat. Congenital hypoplasia of one kidney, pyelonephritis and tuberculosis were the disease entities showing the highest percentage of reduction in blood pressure following nephrectomy.

Ratliff<sup>10</sup> et al in a report of nephrectomy for hypertension associated with unilateral renal disease brought out some interesting facts.

### Pyelograms

During a 6 year study period pyelograms were done on 2,055 patients with hypertension. During this period it was noted that 8.9% of these pyelograms showed some abnormality. These 2000 odd pyelograms represented 20% of the total pyelograms that were done during the same period of time. Of the approximately 2000 pyelograms made 1,350 were made solely for the purpose of demonstrating a possible renal cause of hypertension because none of these patients had symptoms or urinary findings which alone would have indicated the need for urological study. It has been pointed out that the cost of making all of these pyelograms is considerable. However, in any individual case as long as the possibility

that hypertension of unilateral renal origin may be present and amenable to surgical cure one should do pyelography and leave no stone unturned to establish the etiology. Ratliff<sup>10</sup> also studied the records of 49 patients with severe hypertension who were subjected to nephrectomy. A good result was recorded for a patient with a normal blood pressure and no hypertensive symptoms at the time of the final follow up examination. He found 34.6% of his patients had good results following nephrectomy which is similar to the incidence reported by Patton<sup>7</sup>. Best results were obtained in patients with chronic pyelonephritis without hypoplasia (adult type) and in those with hydronephrosis and calculous pyelonephrosis. It is interesting to note that in spite of the high over all expense entailed in diagnostic procedures that a satisfactory result was obtained following nephrectomy in over one third of the operated cases in this series.

### Review of Literature

Langley and Platt<sup>11</sup> in a review of 93 cases in the literature and 10 of their own found that nephrectomy successfully relieved the hypertension in 46 patients with unilateral renal disease. They found more favorable results in cases of pyelonephritis than in calculus or hydronephrosis and pointed out some facts that may be of value as an aid in selection of cases for nephrectomy. About one third of the patients with unilateral renal disease and hypertension will have purely surgical indications for nephrectomy and in the remaining two thirds evaluation of various factors will be necessary. Thirteen of their patients had a family history of hypertension and nephrectomy was successful in lowering the hypertension in only one of these 13 cases; however in 13 other cases with a negative family history for hypertension there were 8 successes. Age in itself in these patients did not contraindicate nephrectomy because 16 of their patients were over 45 years of age and 11 of the 16 were cured and 5 not improved. In the majority of cases the exact duration of the disease was not known but in 21 the duration was longer than 2 years. Success has been reported in some patients who have had hypertension for as long as 10 years.

### Resume of Other Reports

A brief resume of some other reports in the literature concerning the incidence of



Hypertension in various types of renal disease are as follows:

Campbell, E. W.,<sup>12</sup> reported 173 patients with prostatic hypertrophy had an incidence of associated hypertension in 11%; however, with this age group the incidence should be about 50%.

Ritter, W. L.,<sup>13</sup> reported hydronephrosis, whether complicated by stones or infection, does not lead to Hypertension. Twenty-four patients followed 5-10 years with hydronephrosis or lithiasis with or without infection had normal blood pressure throughout the observation.

Braasch, Walters and Hammer<sup>1</sup> indicated that the incidence of hypertension in nephrolithiasis in absence of infection was no greater than in population at large. When infection is present the incidence is a little higher.

Shure, N. M.,<sup>14</sup> reported 62 patients with nephrolithiasis had an incidence of hypertension of 53%. However 83% of these patients were over 40 years of age and 49% were over 60 years of age.

Braasch and Wood<sup>15</sup> stated that 70 patients with clinical perinephritis showed an incidence of only 4.3% of associated hypertension. Most of these were under 50 years of age.

Ellis and Evans<sup>16</sup> recorded that the incidence of hypertension in Renal Dwarfism is rare.

Friedman, Moschkowitz, and Marrus<sup>17</sup> reported that the incidence of hypertension in renal tuberculosis is not unduly great.

Rath and Russek<sup>18</sup> report the same incidence of hypertension in a group of merchant seamen with urological disease (mainly nephrolithiasis, ureteral lithiasis, hydronephrosis and prostatic hypertrophy) as in a control group without urological disease.

Stofer and Kline<sup>19</sup> stated that 38 patients with unilateral or bilateral intra-renal pelvis had the same incidence of hypertension as 38 controls with extra renal pelvis.

Oppenheimer, Klemperer and Moschkowitz<sup>20</sup> report that 18 patients with unilateral renal artery narrowing at autopsy 83% were previously hypertensive and they concluded that the essential hypertension had resulted in generalized arteriosclerosis with incidental renal artery involvement.

Sensenbach<sup>21</sup> reviewed 242 cases of nephrectomy in the literature and found only 47 cured of their hypertension for 1 year. Twenty-two of these had had pyelonephritis and 5 hydronephrosis. 65% of these patients were under 40 years of age.

### Summary and Conclusion

1. Blood Pressure change is our present yard stick for measuring one specific manifestation of many diseases and it is probably a poor method for evaluating the state of underlying disease.

2. The incidence of hypertension in young people is quite low but by the age of 40 is about 20% and rapidly increases to 60% or more in elderly people.

3. There is no absolute evidence that the over all incidence of hypertension is increased by renal diseases such as hydronephrosis, nephrolithiasis, prostatic hypertrophy, intra-renal pelvis, perinephritis.

4. Fully 90-95% of the cases of hypertension fall into essential or hypertension of unknown cause.

5. The best data indicate that unilateral nephrectomy has "cured" 20% of the highly selected cases in which it was performed (or at least lowered blood pressure for one year.)

6. What are the indications for nephrectomy in relation to hypertension and how can the percentage of cures be increased by proper case selection for nephrectomy? Nephrectomy will be indicated in about one third of the cases of unilateral renal disease because of purely surgical indications. In general the younger the patient and the shorter the duration of the hypertension the better probability of a cure following nephrectomy. Unilateral pyelonephritis in patients with no family history of hypertension would seem to offer a better than 50% chance of cure (as measured by a reduction in blood pressure to 140/90 or below for more than 1 year). However, if bilateral kidney disease is present in advanced hypertension as a result of the hypertension itself nephrectomy may shorten life by removal of a portion of the total functioning renal tissue.

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The Second Annual Medico-Military Sym-  
posium will be held at the U. S. Naval Hos-  
pital, Philadelphia, Pennsylvania, October 22  
to 27, 1951. Officers are urged to make hotel  
reservations well in advance, since no govern-  
ment housing facilities will be available. Ad-  
dress all correspondence to Captain M. H. Por-  
terfield, MC, USN, Medical Reserve Program  
Officer, District Medical Office, U. S. Naval  
Base, Philadelphia.

Hugh H. Hussey, Associate Professor of  
Medicine at Georgetown University, Washing-  
ton, D. C., has been appointed associate editor  
of **General Practice**, announces M. F. Cahal,  
managing publisher. Dr. Hussey is a member  
of the House of Delegates of the A. M. A., rep-  
resenting the District of Columbia Medical  
Society.

A grant of \$10,000 to continue a nationwide  
educational program for specialists in the field  
of cerebral palsy has been made by Alpha  
Chi Omega, women's fraternity, to the National  
Society for Crippled Children and Adults, Chi-  
cago. The grant will make possible advanced  
study in the care and treatment of cerebral  
palsied children by specially selected physi-  
cians, therapists and educators during the next  
two years.

Senate Appropriations subcommittee on  
Federal Security Administration reports that  
Oscar Ewing, FSA Administrator, has com-  
plied with its recommendation for a reduction  
of staff in the FSA Office of Publications and  
Reports. The Chavez subcommittee proposed  
fiscal 1952 budget of \$77,000 with 18 employees  
as against budget estimate of \$170,000 and 33  
employees.

The 58th Annual Convention of the Associa-  
tion of Military Surgeons of the U. S. will be  
held at the Palmer House in Chicago, October  
8 to 10, 1951. Members of allied services such  
as nursing, dentistry, etc., as well as physi-  
cians, will participate in the session.

Grants totaling \$1,132,500 were distributed  
to the 79 medical schools of the country on  
July 19 by The National Fund for Medical Edu-  
cation. While physicians contributed more  
than one half of this total, Elmer L. Hender-  
son, M. D., president of the A. M. Education  
Fund, renewed his plea for continued contribu-  
tions from the nation's physicians, since the  
profession has pledged itself to raise a mini-  
mum of a million dollars during 1951.

A.M.A. Bureau of Health Education has re-  
leased to state and county medical societies a  
series of electrically transcribed programs en-  
titled "Gold Medal Doctors," each program  
being devoted to the biography of one of the  
14 recipients of the A.M.A. Distinguished Ser-  
vice Medal. The transcriptions are available on  
application to the Bureau of Health Education  
at A.M.A. headquarters.

The New York Academy of Medicine, 2 E.  
103 St., will hold its Graduate Fortnight Octo-  
ber 8-19, 1951, on "Disorders of the Circula-  
tory System" in collaboration with the New  
York Heart Association.



# *The* JOURNAL *of the* Kentucky State Medical Association

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## THE PAST, THE PRESENT, AND THE FUTURE

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At the Centennial Meeting we will pay our respects to the accomplishments of the past. The present owes much to the past, and it is right and commendable that we recognize our debt, but to become so enamoured of the past that we dedicate ourselves to the preservation of the status quo is to be unworthy custodians of our heritage.

Today is tomorrow's past and yesterday's future. We are determining tomorrow's past today. If tomorrow is to have a glorious past, we must have a successful present.

Our primary obligation is to today. We cannot change the past for it is beyond our grasp, but we can mould and shape the future by developing the opportunities of today. Today's is a changing world. Yesterday's strategies and tactics do not necessarily apply to the problems of today. Conditions change and we must be flexible enough to change with them when

it is advantageous to do so, but we must be inflexible and present a united front in opposition to those who attempt to create a new order in the practice of medicine that would ill serve the profession and the people.

Our elected and appointed leaders and officers are treading in the footprints of those leaders of yesterday whom we will honor at our Centennial Meeting. They cannot achieve more than a fraction of their potential accomplishment without the cooperation of a united profession supporting their individual efforts.

Let us make our contribution today to a great bicentennial celebration in the year 2051 by strengthening our county societies and by lending our cooperation to the leaders of our State Association.

We cherish the heritages that are ours. We can best preserve them by continuing to build upon them.

## CHIROPRACTORS: "WE STAND UNITED AS ONE MAN"

The "Point of View" Column in the Louisville Courier-Journal on July 21 carried a letter signed by W. H. Dunn, D. C., titled "In Defense of Chiropractic." In it the author attempted to justify claims made in a leaflet, (Fig. 1) which was mailed to a large number of Louisville citizens, that chiropractors can determine susceptibility of children to polio, and by two weeks of chiropractic treatment prevent its development. Examinations and treatment were offered free of charge as a "Public Health Service."

In a joint statement released to the Press and to the Better Business Bureau, Dr. Bruce Underwood, State Health Commissioner, and Dr. C. Howe Eller, Director of the Louisville-Jefferson County Board of Health, denied the claims made in the leaflet and stated that the "Public Health Service" was not sponsored by the State Department of Health, the Louisville-Jefferson County Board of Health nor the U. S. Public Health Service.

Dunn's letter to the Point of View Column contained the following most significant statement: "I hope the State Board of Health will not be so foolish as to start prosecution of chiropractors. We have more than 30,000,000 patients in the United States and we stand together as one man when persecution starts."

The significant words are "*we stand together as one man.*" Although physicians might shudder at statements in Dunn's letter regarding "pressure on nerves" and "electrical impulses," there is much that we can learn from the chiropractors in the matter of unity. When he says "we stand together as one man" he is speaking the exact truth. After relating that the State Board of Health had him arrested and tried before the district court five times for the crime of practicing medicine without a license, he says, "... all the chiropractors in the state joined hands to get a straight chiropractic board. We won and have one of the fairest laws in America."

The seal of the Commonwealth of Kentucky depicts two men with clasped hands with the words "United We Stand, Divided We Fall." Strength comes from unity. In the legislative halls of Kentucky, strength is recognized. Is it any wonder that approximately 400 chiropractors who "join hands" and "stand together as one man" can push around 2,400 ununited physicians more or less as they choose in the General Assembly?

Chiropractors also have great respect for the value of public opinion to their profession. Take a look at the situation in your town. Who finds the time to be in attendance at Rotary, Kiwanis, Lions and other civic clubs? Who is present when the lodge meets? Who gives the most time to community and school affairs?

We grant that practitioners should not be judged by such things. Medicine and chiropractic should be accepted or rejected purely upon their relative merit—

## AVOID POLIO

### FREE EXAMINATION AND PREVENTION CARE

Children Ages 1-12 Years

Infantile Paralysis, or Polio, as it is called, is an inflammation of the spinal cord and spinal nerves. By a proper examination of the spine, doctors can tell whether a child is susceptible to Polio!

Hundreds of children who are now seemingly healthy will be stricken with this dreaded disease this summer.

To decrease the number of Polio cases, the Chiropractic Education Association, Inc., has asked Chiropractors of the Louisville area to examine as many children (ages 1-12) as possible to determine if they are likely to be victims of Infantile Paralysis. Any child found to be subject to the disease will be given 2 weeks of Chiropractic care. This length of time is sufficient in most cases to prevent Polio.

The examinations and professional care will be under direct supervision of the Association and will be given free of charge to any child in this age group.

The months of July and August have been set aside for this Public Health Service. Call any of the following telephone numbers to have your child assigned to a doctor of your own choice.

MAgnolia 1332

FRanklin 1200

WAbash 2832

New Albany 4-4234

Jeffersonville 3-3384

CHIROPRACTIC EDUCATION ASSOCIATION, Inc.  
LOUISVILLE, KENTUCKY

Figure 1

or lack of it. But in the field of public relations, the public makes the ground rules. Groups that achieve good public relations carefully observe them.

We know of no group that has more potential strength than the medical profession. We long for the day when, through unity, these latent potentialities may be recognized as a power in the public interest. If Dunn's statements reflect the attitude of 400 chiropractors in Kentucky, it indicates that this group feels that it is unified to such an extent that it can defy the State Board of Health and say, in substance, "Don't start anything for we join hands and stand together as one man."

Isn't there a lesson here?



## INCOME MUST INCREASE OR ACTIVITIES DECREASE

It is decision time when outgo is greater than income. It is precisely this situation which confronts our State Association. Action must be taken if reserves are not to be depleted. Either the outgo must decrease or the income must increase.

In looking at the program which has been built up to meet present demands upon the Association, the Council has decided that it would not be in the best interest of the profession to curtail the activities of the Association to the point that would be necessary if we are to live within our present income. Neither does the Council feel that the present program should be continued by spending the reserves of the Association.

The council voted, therefore, to recommend to the House of Delegates that an-

nual state dues be increased from \$15.00 to \$25.00.

The condition that confronts us is not unique, nor is it an isolated one. Other state medical societies have already found such action necessary and have raised their dues to a realistic figure. The national average of state medical association dues is \$36.66, and there is not one state society whose dues are lower than ours.

Increased expenditures have resulted from an accelerated program, increased activities of a number of committees, and from effects of inflated costs of operation.

The recommendation of the Council will place the matter in the hands of the delegates. They must make the decision.

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### NOT A "NECESSARY EVIL"

Enlightened physicians no longer regard the technical exhibitors at the Annual Meeting as a "necessary evil" which has to be condoned. Today, the technical exhibitor is welcomed to the Annual Session because of the valuable contribution he makes.

Today's technical exhibitor is aware of the role he has been assigned and is conscious of the obligation it carries. The Medical Exhibitor Association, an organization of over 200 companies, is constantly doing research on the problem of how it can best contribute to the success of medical meetings.

The Committee on Technical Exhibits has observed the progress that the exhibitors are making in dignifying their exhibits, discouraging any tendency toward a "carnival atmosphere" and making a highly conscious effort to be scientifically helpful.

Our members will be provided with an

intensely practical exposition at the Centennial Meeting, when sixty-four carefully selected companies—the largest exhibit hall the state has ever had—will offer you information on the latest in drugs, publications, instruments, equipment and services.

These exponents of our system of free enterprise pay from \$125 to \$200 per booth space for the privilege of being present at our meeting. This is only a small part of the expense incurred in "showing" with us. The booth has to be manned, and personnel involved must be maintained. Booth equipment is expensive to purchase, and it must be carefully packed and shipped.

Plan to visit the technical exhibits at intermission time, and before and after the scientific sessions. You will find the experience very profitable.

COMMITTEE ON TECHNICAL EXHIBITS

Carlisle R. Petty, M. D., Chairman

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**Russell F. Staudacher**, research associate in the A.M.A. Council, has given up this post to become executive secretary of both the Student A.M.A. and the A.M. Education Foundation. Leo E. Brown, who has been serving as executive secretary of the Student A.M.A., will devote his full time to A.M.A. public relations.

The annual meeting of the Ambulatory Fracture Association will be held at Arrowhead Springs Hotel, San Bernardino, California, October 8 to 11, 1951. Registration fee is \$15.00. Reservations can be made and programs obtained by writing the Association, 219 North Main Street, Bloomington, Illinois.

# ORGANIZATION SECTION

## R. M. Jones Joins K.S.M.A. Staff As Field Secretary



Raymond M. Jones of Russell, Kentucky, has joined the staff in the Headquarters Office as the new Field Secretary of the Association.

Mr. Jones, a native of Webster County, is a graduate of Kentucky Wesleyan College at Winchester, and has done graduate work at the University of Kentucky. He is married and has one child.

For the past 10 years our new secretary has been Principal of the Russell Central School at Russell, Kentucky. He has also taught in the Jefferson and Webster County school system.

Due to his knowledge of the state in general, his agricultural background, his wide acquaintance with school administrators and his experience with civic club work as a Rotarian, it is felt that Mr. Jones is well qualified to assist in the promotion of the Association's enlarged program.

## County Advisory Committees To Meet During Centennial

A. Clayton McCarty, M. D., Chairman of the Kentucky Medical Advisory Committee to Selective Service, announces a meeting of all County Advisory Committees on Thursday, October 4, at 12:15 (following the adjournment of the morning Scientific Session) in the Assembly Hall, Columbia Auditorium.

Members of the County Advisory Committees, formerly called County Procurement Committees, are listed below by Councilor Districts.

If your County has not sent in to the Headquarters Office the names of its Advisory Committee members, Dr. McCarty urges you to forward them immediately.

**First Councilor District:** Graves—Jacob M. Mayer, Harry M. Roach, Thomas B. Stone, Mayfield; Hickman—Vester A. Jackson, Horace E. Titsworth, Clinton.

**Second Councilor District:** Daviess—G. Ward Disbrow, Allen L. Kincheloe, William B. Negley, Francis M. Sherman, E. Dargan Smith, Owensboro; McLean—Oscar V. Brown, Island,

Andrew B. Colley, Calhoun, Benjamin C. Stigall, Livermore.

**Third Councilor District:** Caldwell—B. K. Amos, Ralph L. Cash, William L. Cash, Princeton; Christian—John E. Baker, Delmas M. Clardy, Charles R. Yancey, Hopkinsville; Crittenden—Edward F. Dombrowsky, Roscoe Faulkner, T. Atchison Frazer, Marion; Hopkins—James A. Freeman, Jr., Dawson Springs, James S. Forbes, Faull S. Trover, Madisonville; Muhlenberg—George F. Brockman, Gathel L. Simpson, Greenville, John P. Walton, Central City.

**Fourth Councilor District:** Bullitt—Bernard I. Popham, Lebanon Junction, James O. Willoughby, Shepherdsville; Hardin—William H. Barnard, Edward E. Johnston, Charles F. Long, Elizabethtown; Larue—John W. Bradbury, John D. Handley, W. J. Shacklett, Hodgenville; Meade—Alfred Glattauer, Brandenburg, Samuel L. Stull, Flaherty; Nelson—J. I. Greenwell, New Haven, John J. Sonne, Kenneth L. Stinnette, Bardstown; Spencer—J. F. Furnish, Martin H. Skaggs, Thomas J. Snider, Taylorsville; Taylor—Michael M. Hall, C. V. Hiestand, Roy G. Wilson, Campbellsville; Washington—Marcus A. Coyle, Richard A. Hamilton, Dixie E. Snider, Springfield.

**Fifth Councilor District:** Jefferson—Raymond C. Comstock, Will R. Pryor, Woodford B. Troutman, Louisville.

**Sixth Councilor District:** Allen—John W. Meredith, Arcy O. Miller, Earl P. Oliver, Scottsville; Barren—Robert L. Chase, Lewis Dickinson, Rex E. Hayes, Glasgow; Butler—David G. Miller, Jr., Morgantown; Edmonson—Sidney E. Farmer, Marcus B. Wilkes, Brownsville; Monroe—George E. Bushong, Tim L. Carter, J. Jack Martin, Tompkinsville.

**Seventh Councilor District:** Anderson—George F. Gilbert, Reuben N. Lawson, J. B. Lyen, Lawrenceburg; Grant—Lenora P. Chipman, Virginia Kratz, Williamstown, Fred R. Scroggins, Dry Ridge, Claude C. Waldrop, Williamstown; Oldham—Henry T. Alexander, Crestwood, George B. Perrine, Pewee Valley, John T. Walsh, LaGrange; Shelby—Alfred D. Doak, William H. Nash, Livingston A. Wahle, Shelbyville; Trimble—O. James Hurt, Bedford.

**Eighth Councilor District:** Campbell-Kenton—Carl W. Kumpe, W. Vinson Pierce, Covington, Arthur F. Schultz, Newport.

**Ninth Councilor District:** Scott—W. S. All-



phin, E. C. Barlow, Henry V. Johnson, Georgetown.

**Tenth Councilor District:** Fayette—John Harvey, Jr., William H. Pennington, John S. Sprague, Lexington; Woodford — Paul E. Corum, Midway, Charles N. Hall, Olson Parrott, Versailles.

**Eleventh Councilor District:** Madison—Max E. Blue, Richmond, J. Bates Henderson, Berea, Marion M. Robinson, Richmond; Montgomery—Joe M. Bush, David P. Edmundson, Paul K. McKenna, Mt. Sterling.

**Twelfth Councilor District:** Boyle—J. Rice Cowan, Oscar L. May, William H. Smith, Danville; Casey—Kearney R. Adams, Garnett J. Sweeney, Liberty; Clinton—Ernest A. Barnes, Samuel W. Bristow, Floyd B. Hay, Albany; Lincoln—James Blackerby, Howard I. Frisbie, Stanford, Milton M. Phillips, Crab Orchard; Mercer—George E. Lowrey, Thomas O. Meredith, C. B. VanArsdall, Harrodsburg; Pulaski—Albert B. Morgan, Enos T. Smith, Robert G. Richardson, Somerset; Rockcastle—Nevil M. Garrett, Brodhead, George H. Griffith, Mt. Vernon, Robert G. Webb, Livingston; Russell—Walter B. Miller, Russell Springs, James R. Popplewell, Jamestown, James B. Tartar, Russell Springs; Wayne—Frank Duncan, Mack Roberts, John W. Simmons, Monticello.

**Thirteenth Councilor District:** Carter—Grady C. Stewart, Olive Hill, Robert G. Townsend, Grayson, W. H. Wheeler, Olive Hill; Elliott—John F. Greene, Sandy Hook; Morgan—Ralph L. Gullett, Hershell B. Murray, Alec Spencer, West Liberty.

**Fourteenth Councilor District:** Myrvin E. Hoge, Cohen F. Lewis, Price Sewell, Jr., Jackson; Floyd—Claude L. Allen, Langley, George P. Archer, Prestonsburg, Robert M. Sirkle, Martin; Letcher—Lundy Adams, Blackey, R. Dow Collins, Lee Moore, Whitesburg; Pike—Tracy I. Doty, Adam G. Osborne, J. C. Preston, Pikeville.

**Fifteenth Councilor District:** Bell—C. K. Brosheer, Arch M. Carr, Jr., Middlesboro, Edward Wilson, Sr., Pineville; Harlan—Henry C. Burkhart, Harlan, James A. Mullen, Benham, William R. Parks, Harlan; Knox—W. Parker Clifton, Theodore R. Davies, Beverly P. Jones, Barbourville; Laurel—Boyce E. Jones, Robert E. Pennington, London; Whitley—L. X. Brown, Williamsburg, William M. Brown, William M. Cox, Corbin.

### **Dr. Henderson, W. M. A. President Attends Stockholm Meeting**

The Fifth General Assembly of the World Medical Association, to be held at Stockholm, September 15-20, 1951, will be called to order

by Elmer L. Henderson, M. D., Louisville, president of the W.M.A.

Secretary General Louis H. Bauer and Executive Assistant Margaret Natwick will leave New York August 31. Dr. Henderson and R. L. Sensenich, M. D., a member of the Council, will leave New York September 7.

### **By-Laws Committee to Recommend Changes to Delegates**

The annual report to the House of Delegates of the Committee to Study the Constitution and By-Laws contains material of interest to you. The Committee is publishing it below for your information.

#### **REPORT OF THE COMMITTEE TO STUDY THE CONSTITUTION AND BY-LAWS**

The committee has carefully studied the Constitution and By-Laws of the Association. We believe the Constitution and By-Laws deserve continued study and that they should be continually revised in the light of changing conditions. We recommend the following proposed changes for consideration at the 1951 meeting of the House of Delegates. We urge all physicians and all component societies to carefully study our proposals and to express themselves to their elected delegates. We should be pleased to have your comments regarding these proposals or any suggestions you may have for additional changes.

Respectfully submitted,

COMMITTEE TO STUDY THE  
CONSTITUTION AND BY-LAWS  
Guy Aud, M. D., Louisville,

Chairman

R. Haynes Barr, M. D., Owensboro  
Charles B. Stacy, M. D., Pineville  
Hugh L. Houston, M. D., Murray  
Bruce Underwood, M. D.,

Louisville

Chapter I, Section 2, of the By-Laws

Change the title and the first sentence to read as follows:

"Section 2. Active Members. Active members shall comprise the active members of the component medical societies." (Note: This will permit qualified Negro physicians to be members of the Kentucky State Medical Association and the American Medical Association provided they are members of a component society as provided in Chapter XII, Section 4, of the By-Laws. Each county society is thus free to accept or reject Negro members as may be desired. If Negro physicians are not accepted by their county society, membership in the state-wide component society will entitle them to membership in the Kentucky State Medical Association.)

Chapter VI, Section 2, of the By-Laws

Change the first sentence to read as follows: "The President-Elect shall be a member of the Committee on Scientific Assembly."

Chapter VI, Section 6, of the By-Laws

Change the last sentence of this section to read as follows: "Either the Treasurer, the President, the Secretary, or the Executive Assistant is authorized to pay money out of the treasury as authorized by the Council or the House of Delegates. All four officials shall give bond in the amount determined by the Council. The Treasurer shall subject his accounts to an annual audit under the direction of the Council. He shall render an annual account of his doings and the state of all Association funds."

Chapter VII, Section 1, of the By-Laws

Revise to include the immediate Past President as an ex-officio member of the Council with a right to vote.

Chapter VII, Section 1, of the By-Laws

Change the next to the last sentence in this section to read as follows: "The Executive Committee shall consist of the President, the Chairman of the Council, the Secretary, and two Councilors to be elected annually by the Council."

Chapter VII, Section 5, of the By-Laws

Change the last sentence to read as follows: "Such communications shall be signed by the President of the Association and the Chairman of the Council as such."

Chapter VIII, Section 1, of the By-Laws

Change to read as follows: "Section 1. The Standing Committees shall be as follows:

- A Committee on Arrangements
- A Committee on Scientific Assembly
- A Committee on Public Relations
- A Committee on Medical Service
- A Committee to Study Constitution and By-Laws

A Medico-Legal Committee

and such other committees as may be necessary. The Headquarters Office at 620 South Third Street, Louisville 2, Kentucky, shall be the headquarters for all committees and activities of the Association except as may be specifically authorized by the Executive Committee. Committees shall be appointed by the President of the Association in conference with the Secretary unless otherwise specified. The President and the Secretary shall be ex-officio members of all committees except as otherwise specified."

Chapter VIII, Section 2, of the By-Laws

Change the first sentence to read as follows: "Section 2. The Committee on Arrange-

ments shall consist of as many members and subcommittees as are appointed by the President of the Association."

Chapter VIII, Section 3, of the By-Laws

Change the first three sentences to read as follows: "The Committee on Scientific Assembly shall consist of five members. The President of the Association shall be a member and Chairman of the Committee. The President-Elect shall be a member of the Committee. The Secretary of the Association shall be a member and Secretary of the Committee. The President of the Association shall appoint one member for a two-year term."

Chapter VIII, Section 4, of the By-Laws

Change the first five sentences to read as follows: "The Committee on Public Relations shall consist of five members appointed by the Council of the Association. The members shall be appointed for a term of three years each, which shall be staggered insofar as possible. The Chairman of the Committee shall be designated by the Council. Under the direction of the Council it shall represent the Association in securing and enforcing legislation in the interest of Public Health and scientific medicine."

Chapter VIII, Section 5, of the By-Laws

Change the first sentence to read as follows: "The Committee on Medical Service shall consist of five members appointed by election of the Council. The terms of each member shall be for three years and shall be staggered insofar as possible. The Council shall annually designate the Chairman of the committee."

Chapter VIII of the By-Laws

Add the following section: "Section 7. The Committee to Study the Constitution and By-Laws shall make a constant study of the Constitution and By-Laws. The committee shall annually make a recommendation concerning changes which it feels should be made in order to keep the Constitution and By-Laws in line with changing conditions and circumstances."

Chapter IX, Section 3, of the By-Laws

Change the section to read as follows: "All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, must have the prior approval of the Council before they can become effective."

Chapter XII, Section 4, of the By-Laws

Change the first sentence of the section to read as follows: "Only one component society shall be chartered in any county except that the House of Delegates may issue a charter to one state-wide society of worthy Negro physicians who are not members of any county society. Membership in the component society thus created shall entitle the members thereof



to all the rights and benefits of membership in the Kentucky State Medical Association."

Chapter XII, Section 12, of the By-Laws

Change this section as follows: "At the time of the annual election of officers each component society shall elect a delegate or delegates to represent it in the House of Delegates of this Association in the proportion of one delegate to each twenty-five members or major fraction thereof and the secretary of the society shall send a list of such delegates to the Secretary of this Association on or before April 1 of each year."

### Two M. D.'s Inducted as Privates Under Doctor-Draft Law

The Army drafted two physicians as privates in July, the first to be inducted under the doctor-draft law, according to the Capitol Clinic bulletin of the A.M.A. Washington office. Others of the 717 Priority I physicians called up presumably received commissions.

Because of a marked increase in Priority I men applying for commissions, the Defense Department asked Selective Service to delay temporarily the induction of 333 Priority I Physicians for August. No reduction in the September call for 152 physicians in Priority I is anticipated, unless Defense should ask for more men in event the August quota was not filled.

The Army first announced drafting of Stanley J. Orloff, M. D., New York, graduate of Tulane University School of Medicine, who reported for duty as private at Camp Kilmer, New Jersey, and will be assigned to Brooke Army Medical Center, Tex. The second draftee is Robert Beconovich, M. D., Hammond, Indiana, graduate of Indiana University School of Medicine, who reported to Fort Sheridan, Illinois, and will also go to Brooke.

### Richmond Entertains Eleventh District

Sixty-five physicians and their wives attended the first meeting of the new Eleventh Councilor District, July 26, at the Richmond Country Club, Hugh Mahaffey, M. D., Richmond, said.

Sam A. Overstreet, M. D., and Bruce Underwood, M. D., both of Louisville, spoke on organizational matters, and Harry Andrews, M. D., Louisville, gave a scientific paper.

The Madison County Medical Society was host to the visiting physicians. After the meal and the welcome, presented by Marion M. Robinson, M. D., the wives departed for their own entertainment, and the medical union was held.

### Fifteenth To Have Annual Meeting

The annual meeting of the Fifteenth Councilor District will be held September 13 at Clear Creek Springs, near Pineville, according to Charles D. Cawood, M. D., Councilor for the district.

Three scientific papers will be presented, the essayists being Robert C. Long, M. D., Louisville, who will discuss "Bleeding in Late Pregnancy"; Allen L. Cornish, M. D., Lexington, who will speak on "The Treatment of Goiter"; and W. Vinson Pierce, M. D., Covington, whose subject will be "Simple Cysts of the Kidneys."

The Bell County Medical Society, of which James Golden, M. D., is president and Fred B. Weller, M. D., is secretary, will be host to the meeting.

### Committee Appoints Two Consultants

The Editorial Advisory Committee announces the appointment of two new members to the Board of Consultants on Scientific Articles to fill vacancies created by deaths.

Richard J. Rust, M. D., a Newport surgeon, will take the place of the late John H. Blackburn, M. D., of Bowling Green. Sam H. Black, M. D., Louisville Pathologist, will serve in the position held by the late Harry M. Weeter, M. D., Louisville.

### Ninth Holds Maysville Session

The new Ninth Councilor District held its first meeting at Maysville, July 13, John R. Cummings, M. D., Flemingsburg, Councilor, has announced.

Sam A. Overstreet, M. D., and Charles E. Reddick, M. D., both of Louisville, spoke. Dr. Reddick substituted for Bruce Underwood, M. D., Louisville, who was ill and could not attend.

A well attended session to which the Mason County Medical Society was host, the program aroused much interest, and a lively discussion followed.

### Sixth District Meets At Glasgow

A dinner meeting at the Glasgow Country Club was held by the Sixth Councilor District, August 14, announced C. C. Howard, Councilor for the district.

Guest speaker Sam A. Overstreet, M. D., Louisville, spoke on "Regional Enteritis," and Guthrie Y. Graves, M. D., Bowling Green, discussed "Diagnosis of Jaundice."

Approximately 55 physicians attended the meeting to which the Barren County Medical Society was host.

# President's Page

## YOUR HELP, PLEASE!

Your committee for the Centennial gave very careful consideration to the provision of some small token commemorating our hundredth anniversary which might be distributed to every member of the State Medical Association. The cost of any useful or desirable article was found to be beyond our means and besides it is most difficult to select a small article, even at any reasonable price, which would be appreciated and kept. We deleted from our plans any foibles such as birthday cakes, floats, or expensive fancy exhibits, and felt that a few activities well done and of permanent educational value would be most appreciated. We regret that we were unable to utilize either television or an elaborate radio performance but these proved more expensive than we felt our Association could afford.

We have undertaken to prepare a single volume to be sold for five dollars to each member who wishes one, which will be a lasting and valuable memorial of our first hundred years. Entitled "The Collected Papers of the Centennial Meeting of the Kentucky State Medical Association," it will contain all the papers presented including the orations in medicine and surgery. Nowhere can be bought for like price a volume which contains such a diversified wealth of material from so distinguished a group of authorities. A photograph and brief biographical sketch of each essayist is planned. In addition there will be a brief biography of Dr. Ephraim McDowell and a short history of

the Kentucky State Medical Association with pictures of all past presidents. Dr. Emmet F. Horine has graciously consented to prepare both the biography and history, and no one is better prepared or more capable of presentations of lasting value. He and his committee are planning the book. Mr. Denhardt, publisher of our Journal, has undertaken the preparation of this volume, and economies obtainable only through his experience and goodwill make possible this most reasonable price.

This is an enterprise in which every member should share. It cannot be a money making proposition but at the same time we cannot afford to allow it to prove a financial burden to the Association. One thousand volumes must be sold before we can hope to break even. If two thousand are bought, there may be a little profit which will be used to help defray the unusually heavy expenses of this meeting. We trust that every one attending the Centennial will purchase one or more copies. We all have medical colleagues in or outside the State who would appreciate and treasure such a gift. They will make fine Christmas presents.

At or near the registration desk will be a table with secretaries on duty at all hours during the meeting prepared to take your orders—and your money. You will be reminded. Don't pass them by. This is a cooperative effort—we must make it a successful one.

*Sam A. Overstreet*

PRESIDENT



# County Society Reports

## FAYETTE

The regular meeting of the Fayette County Medical Society was held in the Good Samaritan Hospital Auditorium July 10, 1951.

The meeting was called to order at 7:30 P. M. by the President, William H. Pennington, M. D.

William E. McDaniel, M. D., presented a paper "The Problem of the Pigmented Mole," and illustrated it with lantern slides, kodachromes and microphotographs. The paper was discussed by Drs. C. C. Barrett, Elmer S. Maxwell, Carl H. Fortune, Edwin F. Kanner and by Dr. McDaniel in closing.

The committee appointed to report to the Society on the wishes of the members concerning membership in the Blue Cross Plan of Hospital Insurance requested that their report be deferred until next month.

The President raised the question of election of a permanent committee of the Fayette County Medical Society to act in cooperation with the State Committee for Military Procurement in case or time of need. It was moved by Edward J. Murray, M. D., seconded and passed without dissent that the Chair appoint three members of the Society to constitute such a committee. Dr. Pennington appointed Drs. Carl Fortune, John Harvey, Jr., and Francis Massie to constitute this committee.

The applications for membership in the Society of Drs. Carl M. Friesen, John W. McGowan, Fred P. Moverly and D. Maurice Royalty were read and referred to the Board of Censors for approval.

Dr. Bullock spoke to the Society briefly concerning the Ephraim McDowell Memorial House in Danville and the need for money to help the local Woman's Auxiliary finish the

equipping of the Fayette County Room. It was moved by John Scott, M. D., and seconded by John B. Floyd, M. D., that the Society allocate \$750.00 from its funds to the Woman's Auxiliary to be used by them in completing the requirements of the Fayette County Room. After discussion by Drs. Fortune, Walter S. Wyatt and Caroline Scott the motion was voted upon and passed without dissent. The Treasurer was instructed to transmit the funds as above mentioned.

Sam Marks, M. D., called the attention of the Society to a recent report with regard to the use and remarkable efficacy of ACTH for treatment of Black Widow Spider bites.

There being no further business, the meeting was adjourned at 8:40 P. M.

John S. Sprague, Secretary

## SCOTT

The Scott County Medical Society held its regular monthly meeting at Mrs. Jesse Ashurst's at noon on Thursday, August 2, 1951 with the following members present:

Drs. W. S. Allphin, E. C. Earlow, L. F. Heath, P. H. Crutchfield, F. W. Wilt, A. F. Smith, H. V. Johnson and guest, W. W. Richardson of Paris, Kentucky.

Minutes of the previous meeting were read and approved.

Dr. W. W. Richardson of the Paris Tuberculosis Hospital was the guest speaker. He gave a most interesting talk on his work and showed some chest films of Scott County patients who are being treated.

After Dr. Richardson's talk a round table discussion was held and the meeting adjourned to meet the first Thursday in September.

H. V. Johnson, Secretary

## News Items

**Ray Smith, Executive Secretary of the Indiana State Medical Association**, who spoke at our first Annual County Society officers' conference March 1, died of a heart attack at his home August 4. Mr. Smith was regarded as one of the leading medical executives and was a member of the A.M.A. Public Relations Committee.

**Woodford B. Troutman, M. D.**, 1616 Heyburn Building, Louisville, announces his association with **Ralph M. Denham, M. D.**, in practice limited to Cardio-Vascular diseases. Dr. Denham is a graduate of Vanderbilt University School of Medicine in 1942, and interned and had residency at the Henry Ford Hospital, Detroit. He is a Diplomate of the American Board of Internal Medicine.

**Clark Bailey, M. D.**, and **Walter L. Cawood, M. D.**, Harlan, have announced that **George R. McElroy, M. D.**, is now associated in practice with them. A graduate of the University of Tennessee College of Medicine in 1950, Dr. McElroy interned at William Beaumont Army Hospital, El Paso, Texas.

**W. Reeve Hansen, M. D.**, and **Robert L. McClendon, M. D.**, have opened an office in the Francis Building and will be associated in the practice of internal medicine and cardiology. A native of Utah, Dr. Hansen is a graduate of University of Louisville in 1945 and interned at the U. S. Naval Hospital, Ft. Eustis, Virginia. Dr. McClendon is from Montana, a graduate of the University of Louisville in 1945, and interned at the U. S. Marine Hospital, Norfolk, Virginia. Both have done additional work at Nichols Veterans Administration Hospital and Louisville General Hospital.

**Claude C. Waldrop, M. D.**, Williamstown, has announced that **Smith H. Gibson, M. D.**, Evarts, is now associated in practice with him. Dr. Gibson is a graduate of the University of Louisville School of Medicine in 1950, and recently completed his internship at St. Elizabeth Hospital, Covington

**F. V. Smith, M. D.**, who limits his practice to psychiatry, has opened an office in the Finckle Building, Louisville. He received his University degree at the University of Kansas City in 1938 and graduated from the University

of Louisville School of Medicine in 1942. After taking his internship in Kansas City General Hospital, he went on active duty in the Navy Medical Corps. His residency training in psychiatry was taken at Nichols Veterans Administration Hospital, Louisville, Louisville Mental Hygiene Clinic and The Norton Psychiatric Clinic.

**William C. Durham, M. D.**, has located at 317 Wallace, Louisville, where he will specialize in obstetrics and gynecology. After graduating from the University of Louisville School of Medicine in 1944, he interned at the Marine General Hospital, Norfolk, Virginia, and has been at Louisville General Hospital since 1949.

**Allen Grimes, M. D.**, Lexington, has taken **William T. Swartz, M. D.**, Cincinnati, as an associate in the practice of general surgery. After graduating from Northwestern University Medical School in 1945, Dr. Swartz interned and took a residency at Cincinnati General Hospital. He served in the Army, and was connected with the Veterans Administration Center, Dayton, Ohio.

**Charles J. Bisig, M. D.**, a graduate of the University of Louisville in 1944, has opened his office in the Brown Building, Louisville, for the practice of surgery. A native of Kentucky, he interned at St. Joseph's Infirmary, Louisville, served in the Army, and has returned to Louisville from Charity Hospital, New Orleans, Louisiana.

**Frederic C. Hauck, M. D.**, has located at Falmouth. He is a graduate of the University of Louisville in 1950. He interned at City Hospital, Cambridge, Massachusetts.

**Clinton L. Border, M. D.**, has announced the opening of an office in Horse Cave. Dr. Border, a surgeon, is a graduate of the University of Louisville School of Medicine, 1929.

**W. H. Fuller, M. D.**, Fuller-Morgan Hospital, Mayfield, announces his association with **Mahlon M. Harlan, M. D.**, Barlow. Dr. Harlan is a graduate of the University of Tennessee College of Medicine in 1950, and interned at General Hospital, Fresno, California.



**Bert C. Wiley, M. D.**, who specializes in physical medicine, is opening an office in Lexington. Dr. Wiley, a graduate of Ohio State University College of Medicine in 1943, interned at Nashville General Hospital and later at Miami Valley Hospital, Dayton, Ohio. He practiced in Dayton from 1944 to 1950.

**James J. Kelly, M. D.**, has opened an office in Ludlow and will specialize in pediatrics. A graduate of the University of Cincinnati College of Medicine in 1946 and a native of Arkansas, he interned in Louisville General Hospital and served a residency at the Louisville Children's Hospital.

**Wreno M. Hall, M. D.**, has opened an office at Mt. Sterling. Dr. Hall is a graduate of the University of Louisville School of Medicine in 1950 and interned at the Good Samaritan Hospital, Lexington.

**George C. Stege, M. D.**, has located at 1717 Herbert Ave., Shively. Graduating from the University of Louisville School of Medicine in 1950, he interned at St. Mary & Elizabeth Hospital, Louisville.

**Charles E. Pearce, M. D.**, has located at 101 S. Hubbards Lane, Louisville. A native of Indiana and a 1950 graduate of the University of Louisville, he interned at St. Joseph Infirmary, Louisville.

**Robert T. Hollingsworth, M. D.**, has begun his practice at Insull, Harlan County. A native of Mississippi, Dr. Hollingsworth graduated from the University of Tennessee College of Medicine in 1951.

**Wayne B. Stone, M. D.**, has located at Cloverport. He is a graduate of the University of Arkansas School of Medicine in 1932 and interned at the Schumpert Memorial Hospital, Shreveport, Louisiana. After his discharge from the Navy in 1945, he was with the Veterans Administration.

**Robert B. Simons, M. D.**, Lexington, is specializing in internal medicine. A native of Maryland and a graduate of Columbia University College of Physicians and Surgeons in 1945, he interned at the Henry Ford Hospital, Detroit, and served in the Navy before taking a residency at Henry Ford.

**J. H. Chrisman, M. D.**, Owenton, celebrated recently his fifty-ninth year as a physician. Receiving his diploma from the Louisville School of Medicine in 1892, he practiced one year at Holbrook, twelve years at Jonesville,

and then moved to Owenton where he has practiced ever since. Dr. Chrisman has delivered over 3,000 babies, all of them in the home.

**George D. Lavers, M. D.**, surgeon, has opened an office in Kenvir, Harlan County. Dr. Lavers is a graduate of the Alberta Faculty of Medicine in 1943 and interned at the University of Alberta Hospital and the Royal Alexandra Hospital, Edmonton, Alberta.

**John M. Smith, Jr., M. D.**, formerly with Navy Recruiting in Louisville, has located at Beattyville. Dr. Smith is a graduate of the University of Louisville School of Medicine in 1949 and interned at Naval Hospital, St. Albans, New York.

**Norman C. Wheeler, M. D.**, has located in Berea. Born in Lawrence County, Dr. Wheeler received his degree from the Medical College of Georgia in 1950 and interned at St. Joseph Hospital, Lexington.


**Richard L. Colley, M. D.**, has started a practice in Mayfield. A native of Kentucky, Dr. Colley is a graduate of the University of Louisville School of Medicine in 1950 and interned at Brooke General Hospital, Ft. Sam Houston, San Antonio, Texas.

**William Gerald Edds, M. D.**, will open an office in Calhoun. A graduate of the University of Louisville School of Medicine in 1950, Dr. Edds has served in the Navy and recently completed his internship at the U. S. Naval Hospital, Portsmouth, Virginia.

**Charles D. Clark, M. D.**, a graduate of the University of Tennessee Medical School in 1950, has joined the medical staff of the A. D. Butterworth Clinic, Murray. He comes to Murray from Memphis where he has been connected with the Baptist Memorial Hospital.

**Clyde Nichols, M. D.**, a graduate of University of Louisville in 1950 who interned at Louisville General Hospital, has opened an office in Clarkson, Grayson County.

**Edgar B. Morgan, M. D.**, a graduate of the University of Louisville in 1950, has just finished his internship at the Baptist Hospital, Louisville, and has opened an office at 2708 Frankfort Ave. in Louisville.



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## *In Memoriam*

**GEORGE W. THRELKELD, M. D.**

Mount Washington

1875 - 1951

Dr. George W. Threlkeld, retired Veterans Administration surgeon and a native of Mount Washington, died Tuesday, August 14, 1951.

Southern Baptist Theological Seminary, Kentucky Baptist Orphans Home, and Masonic Widows and Orphans Home were made beneficiaries of his very large estate. For many years Dr. Threlkeld had been an ardent supporter of the seminary.

Dr. Threlkeld was graduated from the Kentucky School of Medicine, Louisville, in 1900 and had served the Veterans Administration for twenty-five years, and since his retirement from active practice he has made his home in his native town.

**JOHN G. RENAKER, M. D.**

Dry Ridge

1878 - 1951

Dr. John G. Renaker, for many years a physician at Dry Ridge, died Wednesday, May 30, 1951, at his Covington residence. He was born in Grant County in 1878. Dr. Renaker began practicing medicine in Dry Ridge soon after receiving his M. D. degree in 1898 from the Kentucky School of Medicine, Louisville, and moved to Covington in 1927, retiring in 1946.

**ALBERT L. BASS, M. D.**

Louisville

1887 - 1951

Dr. Albert L. Bass, retired Louisville physician and instructor at the University of Louisville School of Medicine, died July 18, 1951. A native of Campbellsville he was a graduate of Centre College and received his medical degree from the University of Louisville Medical Department in 1912. Dr. Bass served as a captain in the Medical Corps during World War I.

He was a specialist in eye, ear, nose and throat diseases and had offices in the Heyburn Building. Dr. Bass had been a practicing physician for thirty-seven years and had taught at the University for thirty-one years.

He was a member of the staffs of Kentucky Baptist Hospital, Norton Memorial Infirmary, and St. Joseph Infirmary. He was a member of the American Board of Otolaryngology.

**E. W. HOWELL, M. D.**

Oakton

1878 - 1951

Dr. E. W. Howell, widely known physician of Oakton who had practiced in Hickman County for the past forty-five years died Monday, July 30, 1951 after an illness of several weeks.

Dr. Howell was graduated from the University of Louisville Medical Department in 1907 and had practiced in Oakton since that time.

**JUNIUS B. SHACKLETTE, M. D.**

Louisville

1882 - 1951

Dr. Junius B. Shacklette, Highland Park, Louisville, died July 16. He was a graduate of the old Kentucky University Medical School in 1906. He practiced medicine in his native city since 1906. In 1929 he opened a drug store and later added a department store. He was born in Meade County and was a member of his county and state organizations. He had retired from practice some years ago.

**F. W. TYREE, M. D.**

Hitchins

1871 - 1951

Dr. Fred Werner Tyree, Hitchens, died May 18, 1951. Dr. Tyree had been a practicing physician for fifty-three years and was company doctor for the General Refractories Company and the Chesapeake and Ohio Railway. He had also served with the United States Navy as a surgeon.

Dr. Tyree was graduated from Kentucky School of Medicine, Louisville, in 1897.

**WILLIAM J. COYLE, M. D.**

Louisville

1910 - 1951

William J. Coyle, M. D., died at his home in Louisville of a heart attack. He was formerly associated with Dr. E. L. Henderson, Past President of the American Medical Association. He recently occupied an office in

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Medical Director

T. J. SMITH, M. D., Associate



the Francis Buiding. He received his preliminary education at the University of Pittsburgh and graduated from the University of Louisville School of Medicine in 1939.

Dr. Coyle was on the staffs of the Kentucky Baptist, St. Anthony's and SS Mary & Elizabeth Hospitals and St. Joseph Infirmary and was a member of the American College of Surgeons.

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#### DR. CHARLES EMMETT YOUMANS

Frankfort

1895 - 1951

Dr. Charles Emmett Youmans, Frankfort, died May 19, 1951. He was born May 29, 1895, at Baxley, Georgia, and came to Frankfort in June, 1923, and had been connected with the Kentucky Training Home almost continuously since that time, for the past seven years serving as superintendent. Dr. Youmans was graduated from the University of Louisville School of Medicine in 1921.

He served in World War I and was a member of the Franklin County Medical Society, Kentucky State Medical Association, Kentucky Psychiatric Association, American Association of Mental Deficiency, and a Fellow of the American Medical Association.

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#### PALMER H. REED, M. D.

Paducah

1905 - 1951

Dr. Palmer H. Reed was born December 5, 1905, Paducah, Ky. He attended Tilghman High School and then went to the University of Kentucky for his pre-medical training. He graduated from Tulane Medical School in 1928 and after a year's internship went into practice in Shreveport, Louisiana. Later he moved to Paducah and was in practice there until 1945 when he moved to El Paso, Texas, where he died June 30, 1951.

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#### JOHN L. COX, M. D.

Campton

1885 - 1951

Dr. John L. Cox, Campton, died at his home Sunday, June 10, 1951, following an illness of several months. Dr. Cox had been in public health work for twenty-three years serving in Wolfe, Morgan, Lewis and Carter counties. He was graduated from the University of Louisville Medical Department in 1906.

#### ANTHONY WAYNE BROMLEY

Louisa

1869 - 1951

Dr. Anthony Wayne Bromley, Louisa, died June 17, 1951. Dr. Bromley was born at Fort Gay, Wayne County, West Virginia, on November 27, 1869, and was graduated from the Eclectic Medical School at Cincinnati in 1896. With his father-in-law, the late Dr. L. H. York, he operated the Riverview Hospital, Louisa, for more than forty years.

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## BOOK REVIEWS

#### PUBLIC HEALTH AND WELFARE IN JAPAN —Annual Summary 1950 by Crawford F. Sams, Brigadier General, Medical Corps Chief.

This is the third in a series of summaries containing information on the progress of the Public Health and Welfare Section, General Headquarters, Supreme Commander for the Allied Powers, in accomplishing the health and welfare objectives of the Occupation mission.

This third publication covers the calendar year 1950 and contains further information on those programs discussed in the two previous summaries. Included as an appendix are tables containing statistical data on public health and welfare activities in this country.

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#### LET'S COOK IT RIGHT: by Adelle Davis, B. A. M. S., Published by Harcourt, Brace and Company, New York 1947. Price \$3.00.

The reviewer first saw this book in the library at the State Department of Health, Jackson, Mississippi, and was so impressed with its simplicity and its many helpful recipes that it was immediately ordered. The days are past when a doctor can order a soft or hard diet and he should know the reasons there are for ordering special foods.

As bread is one of the most important foods, it has been robbed of much of its nutritive value in the present day set-up, and it is interesting to note that the author has devoted several chapters on breads and especially the use of the whole cereals.

This book is well illustrated and also gives the equivalent measures which are very essential in all arts of cookery.

Let's Cook it Right contains 350 basic recipes for preparing every variety of food, and over 3,000 variations of them. Thus endless repetition is avoided in the text and greater flexibility allowed the cook who enjoys being creative. All the recipes are simplified and the suggested procedures shortened as much as possible.

# *The* JOURNAL *of the* Kentucky State Medical Association

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## PREVENTION OF ECLAMPSIA

Robert A. Orr, B. S. M. D.

From Department of Obstetrics, Fuller-Gilliam Hospital, Mayfield

MAYFIELD

The subject, "Toxemia of Pregnancy," has occupied the attention of many obstetricians, exemplified by the profuse if not always erudite discussions in the literature. One can hardly scan an issue of an obstetrical journal, or any other medical publication, for that matter, without finding articles on some phase of its ramifications.

I remember well, in my medical school days, running across and wholly devouring an article on the "Stroganoff Treatment of Eclampsia." Stroganoff claimed a mortality of 6% and a corrected death rate of 3.8 percent in a series of 1399 Eclamptic patients. I could hardly wait to start on the obstetrical wards to put this new found knowledge to the test. However, it did not take me long to realize, though this treatment resulted in life saving measures for the Eclamptic and often the fetus, that it was better for me to consider the patient from a different standpoint, i. e., what could I have changed in the prenatal care to prevent the seizures?

All of us assembled here have witnessed many times Eclamptic convulsions. It is not necessary therefore for me to describe to this society the clonic seizures of the eclamptic or the jactitation between convulsions. But I do think it is most timely to consider simple and proper methods to combat Eclampsia by treating Toxemia or Pre-Eclampsia early before the eclamptic state is reached.

### Etiology

The etiology of the disease is unknown, although the number of causes postulated, past and present, is legion. It seems fairly

certain now that Eclampsia is not caused by uremia, bacterial infection nor edema per se. These old theories and others may be discarded because of data which have been accumulated in many hospitals and research institutions.

Stander divides the etiology of Eclampsia into three groups.

1. Causes postulated outside maternal organism.
  1. Dietary deficiency.
  2. Infection.
  3. Meteorologic influence.

### Dietary Deficiency

An approach was made by Burk (1943), who conducted a dietary survey during the last trimester of pregnancy. Her report showed that 44 percent of the patients in the "very poor" and "poor" groups developed pre-eclampsia and 8 percent in the "fair" group. There was no Eclampsia in the "good" and "excellent" diet groups. These good and excellent diets contained adequate protein, calcium and vitamin content.

As Stander points out the classic criticism of this postulate is the observed decrease in the incidence of Eclampsia in Germany during World War I and a similar decrease in Holland in World War II. This seems to lead us to the conclusion that overeating and a rich diet of prosperous people may be the culprits. Anyway a dietary theory of Eclampsia to be valid must explain these decreases.

II. Causes postulated within maternal organism.

1. Constitutional predisposition.
2. Pressure theory.

Read before the Meeting of the Obstetrical and Gynecological Society, Louisville, April 28, 1950.



3. Endocrine imbalance.
  - (a) Pituitary.
  - (b) Adrenal cortex.
4. Chemical poisons.
  - (a) Guanidine.
  - (b) Histamine.
  - (c) Tyramine.

### Hormone Theory

Smith and Smith in 1934 found the blood and urine gonadotropins to be higher and the estrogens lower in toxemic than in normal patients. These changes began some weeks before the onset of toxemia. There is also decreased excretion of pregnanediol. While these findings have not been entirely supported by subsequent work, they seem a step in the right direction. It is further thought that the decrease in hormones might be due to a decrease in blood supply to the placenta either by infarction or by increased cholesterol deposits within the blood vessels leading to the uterus.

### Histidine Theory

Another popular theory advocated by Hofbauer in 1926 is the Histidine theory. The finding of histidine and histamine in the urine of patients suffering from conditions such as hyperemesis gravidarum, threatened abortion and mild pre-eclampsia led her to believe that these were not separate diseases, but manifestations of the same disease.

III. Causes postulated within products of conception.

- A. Placenta.
  - (1) Infarct.
  - (2) Ischemia.
  - (3) Crush Syndrome.
  - (4) Allergy.
  - (5) Elements.
- B. Fetus.
  - (1) Endocrine imbalance.
  - (2) Iso-Immunization.
    - (a) Rh Factor.

### Placenta Theory

The placenta seems to be implicated in the etiology, but there seems to be some factor in the body or the lack of some factor which should cause changes in the placenta which in turn would cause toxemia—as pointed out above. The advocates of the placenta theory evolve the decreased blood supply to the placenta either by infarction or by hypercholesterolemia.

So far as the Rh Factor is concerned there seems to be little or no evidence

that Rh incompatibility causes toxemia.

Finally, as Stander sums up the various theories, there seems to be enough theories, but as yet we are uncertain as to the etiology of toxemia and only further well directed research into the disease will give the final story.

### Water Balance Theory

I am loath to leave the review of etiology of eclampsia without reference to recent work by Diekman, et al, on the subject of "Water Balance." In spite of much improved obstetrical care and carefully compounded diets, we still have not been able to prevent pre-eclampsia and occasionally a case of eclampsia in our patients. Improved results in therapy result from obstetricians, generally, recognizing the importance of too much weight gain and in their limiting the sodium intake of the patient. It is a well known fact that women buy salt and baking powder in large quantities and use each freely in cooking. Our patients eat too much and drink too little. Many women worry about finances, marital unhappiness or their pregnancies. The primitive native woman has many diseases but she escapes overeating and worry of her civilized sister, and as a rule she rarely has Eclampsia. I am sure you, as I, have found it most difficult to control the weight gain of obstetrical patients. It is a subject that the doctor must stress continually and argue with the most intelligence. I spend more time showing my patients the danger of overeating than I do on any other phase of prenatal care. Usually, women will do without salt in their diets because they feel they are sacrificing something for the baby. They crave food, and no manner of cajoling will prevent them from adding a little food here or there which isn't on the diet list. As a result instead of limiting their weight gain to 20 to 25 pounds, the average weight gain of my patients is about 40 pounds. (I wish to point out in passing, since I referred to sodium intake above, it doesn't do any good to limit salt in one's diet if sodium bicarbonate is allowed at will.)

But to get back to the water balance theory. Many investigators believe there is first a salt and water retention due to abnormal capillary permeability. Some patients develop a hypertension (which may be compensatory), proteinuria due to edema of the kidneys or to vaso constriction, and a very few develop convulsions or coma or both. (Again the result

of vaso constriction). Diekman has found that all pregnant women have increased water retention due to involvement of the antidiuretic substance from the posterior pituitary and the hormones from the adrenal cortex.

The delay in excreting water may be due in part to the water storage in the thighs and legs as the result of high venous pressure in the lower extremities due to the greatly enlarged uterus pressing on the large veins of the abdomen. A urinary output of 2,000 cc. per 24 hours is recommended as the optimum and this may be achieved by the patient drinking 150 to 200 cc. of water hourly. Also Diekman pointed out that the administration continuously of glucose intravenously for several days not only increased the elimination of sodium in the urine but also caused diminution of volume of extracellular fluid.

### Incidence

The incidence of Eclampsia as found by Diekman is a mean of one percent in the world. Eclampsia is becoming rarer each year due to improved prenatal care. The disease is more common in warm than in cold climates. It is more frequent in multiple than in single pregnancies, and is found four to five times more often in those women with polyhydramnios. It is a moot question whether one who has had Eclampsia will be more apt to have a recurrence of the disease in subsequent pregnancies. Not many of us will take the chance that it won't recur, we simply watch them a little more closely.

Since the cause of Eclampsia is not certain, treatment is empiric.

### Therapy

Smith and Smith have proved in a controlled series that ingestion of increasingly large doses of diethylstilbestrol beginning with the 12th week of pregnancy and continuing through the 35th week would lessen the incidence of pre-eclampsia and eclampsia. This therapy consisted of giving 12.5 mg a day during weeks 12 and 13. Beginning weeks 14 and continuing through 16, 25 mg a day was taken. Beginning the 17th week 50 mg was started and this amount was continued through the 20th week. It was then raised to 75 mg per day for weeks 21 through 25, 100 mg for weeks 26 through 30 and 125 mg for weeks 31 through 35. If therapy was started after the 12th week the daily dosage was that for the week of pregnancy when

the therapy was begun. Smith stated except for the minor side effects of itching or mild nausea no untoward effects were noted and that in no instance did the drug have to be discontinued.

Hofbauer recommends the use of a diet adequate in Vitamins B and C and of calcium which exercises a protective power in relation to the liver. All essayists note the importance of the low fat diet and the maximum weight gain of 20-25 pounds during the entire 40 weeks of gestation.

Diekman forces the fluid intake of his patients to 150 to 200 cc. hourly and limits the sodium intake to 2 grains a day and the chlorides to 4-6 grains per day. He allows 1-2 grains of potassium in a 24 hour period.

### Low Sodium Diet

Davis stated emphatically at the Mid-South Medical Convention in Memphis in 1947, I believe, that a low sodium diet and a limited weight gain of not over 20 pounds would lessen the incidence of toxemia and cause Eclampsia to become an oddity.

### Prenatal Care

In the author's series of approximately 630 cases there have occurred two cases of Eclampsia with no maternal or fetal deaths. This is attributed to frequent prenatal visits to the clinic. At each visit the patient is weighed, her blood pressure is taken and recorded, her urine is carefully checked for albumen and casts. She is interviewed and examined so that symptoms of persistent headache, edema of the face or extremities or a decrease in the amount of urine secreted will not be overlooked early. Nausea and vomiting are controlled and diets are discussed with proper emphasis on the patient's responsibility not to allow herself to gain over the maximum weight-gain allowed.

### Prevention

The prevention of Eclampsia, therefore, is the proper hygiene of pregnancy. Every pregnant woman should be considered a potential eclamptic. Under no circumstances should the antiquated method be continued of the patient's husband going to the doctor just prior to his wife's confinement to inform him of his wife's pregnancy and to tell him that he expects him to deliver her. And, usually, they state the wife would have been to see him but she was getting along fine except for



certain symptoms that fall within those symptoms of toxemia.

If obstetricians or doctors practicing obstetrics would as a group refuse to render such midwifery this practice would be discontinued. I am happy to state such occurrences are dying well deserved deaths, but I do know of two cases in our community, happening within the last year.

Proper education of the people by the doctors and the lay literature, as well as the doctor having a positive approach to prenatal care, will alleviate, if not completely eradicate, Eclampsia.

### Summary

1. Etiology of Eclampsia reviewed.
2. We are as yet uncertain as to the etiology of Eclampsia.
3. We are not able by proper diet or by obstetric care to prevent an occasional case of Eclampsia.

4. Elimination of water taken by oral or intravenous routes is delayed in all pregnant women, but more so by the toxemic patient.

5. Frequent ingestion of small amounts of water aid in increasing the total amount of urine secreted as well as a diminution in the water content of the cells.

6. Restricted gain in weight and restriction of ingestion of sodium seem to aid in the prevention of Eclampsia.

7. Proper prenatal management, as well as proper education, has decreased Eclampsia.

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## PSYCHOSOMATIC CONDITIONS OBSERVED IN 1,000 CONSECUTIVE OFFICE PATIENTS

W. O. Johnson, M. D.

LOUISVILLE

The attitude of the medical profession regarding the causes and treatment of disease has changed greatly in the past thirty years. With the development of Psychiatry, the emotional causes of disease have been brought out. Social Service also developed the relationship between bad economy and bad health, and since the depression in 1929, the relationship of insecurity and disease has become more apparent. The incidence of fatal illnesses in younger men, resulting from cerebral causes and coronary thrombosis are exaggerated by anxiety and the stress of the times. And likewise in surgery, the "great of the past" who needed no post-operative care, have vanished, and now the meticulous care, before and after operations, in addition to improved surgical skill, have filled their places.

These changes all broaden our concepts as to the causes of diseases, from the purely physical and pathological causes, to include to some degree the psychological, emotional, and the functional causes, produced by economic and social factors.

Therefore I thought a study of a group of 1000 consecutive cases, following the end of World War II, in the years 1946-47, would be of interest, and perhaps might show some trends in our thoughts about disease. The analysis is along psychosomatic lines, but the statistics presented or situations cited, in no way should lead you to believe that I have switched from the practice of gynecology to the practice of psychiatry.

### Diagnosis

The diagnosis of psychosomatic disease would depend on demonstrable organic pathology, either subjective or objective, with the emphasis on objective, associated with evident and objective emotional factors. In other words, to the physical examination, the bare facts of medical history and laboratory studies, we add a personality study. In this way we eliminate diagnosis by exclusion, and get a positive psychosomatic diagnosis.

One must keep in mind that both functional and organic problems occur in every practice and we must analyze each patient carefully from these points of

view. Organic illnesses may give rise to fears which exaggerate the symptoms, and be a factor in the etiology of a full blown psychoneurosis or emotional problem.

### Normal Expectancy Study

As a method of comparison let us first find what the normal expectancy will be in an analysis of groups of patients that have undergone physical examinations.

The results of examinations among 1,998 women, who had pelvic examinations as routine in being examined for the Navy (1). These women had volunteered and wished to pass the physical examination. Of this group 6.6% would only permit a rectal examination, because of intact hymen. The number of single women was 91%, and there was a history of 27 pregnancies. The ages ranged from 21-50 years. Of this group:

1,279 women had normal pelvic findings.

719 defects were found.

291 defects required treatment.

Approximately one-third of the women had some type of gynecological condition, predominantly of a minor nature. This may be criticized because they do not represent all walks of life, and many had well developed maladaptations to life.

Another study by Augusta Webster on a group of 2000 well women, who came from all walks of life, between the ages of 18-65 years, with no specific complaints, but wanting a periodic examination (2). This group likewise shows minor pathology, still within the 30% of the cases examined.

One can then surmise that the normal expectancy is that about 30% of apparently normal women will have some kind of minor gynecological condition present.

### Age Incidence

In the study of the age groups of our 1000 cases, we find that 90% are in the child bearing age; and that 60% are housewives, but we cannot say that occupation has any distinct bearing upon their condition.

In the majority of instances we find that the real pathology is associated with the sequela of child bearing, and the resulting deficiencies of age. The conditions present usually are not of so much importance as the patient's interpretation of the symptoms and ailments in relation to her body and her environment. As a marked hyperthyroidism in a Swedish

descendant is not as great as mild nervousness in the Semitic race.

We find a total of 1,817 children among 722 women that had been pregnant, which is an average of 2.5 children to each woman. Approximately 278 of the women above had not had any pregnancies. This ratio is below the average fertility rate of our people, which varies from 3.2 to 3.7 children per family.

### Group With Children

In the analysis of this group we will for clarity of discussion, divide them into three groups:

Group I—Those cases with organic disease, which is the cause of the symptoms complained of, and requires correction by medication or surgery.

Group II—Those who have organic disease, that may or may not be affected, but the predominant symptoms arise from the functional disorders.

Group III—Those disorders that are purely functional in origin, with no demonstrable organic disease.

### Discussion of These Groups

The lines of division between these three groups are not always clear cut. In fact, there is no such thing as an exact line between functional and organic symptoms. It is therefore merely a matter of degree, all organic ailments have functional modifications, and functional disorders can produce organic changes. The highest ten numbers of complaints, diagnoses, and treatments, have been given in each of the three groups as follows.

In Group I, which is made up of organic conditions, the majority of these patients had been diagnosed by other physicians or had been sent or came to me for surgery. There were 536 operative cases, with 660 chief complaints in the first ten listed symptoms. This makes about two or more symptoms for each patient, and more than two conditions diagnosed in each case. The numbers therefore do not tally for there are many symptoms in smaller groups, too small to enumerate.

In all of the groups there are many duplications of complaints and findings, and as I mentioned in the beginning, the divisions overlap and are hard to separate.

The presence of a pelvic abnormality per se does not of necessity explain the symptomology, nor does the pelvic lesion invariably cause symptoms.



## GROUP I (536)

COMPLAINTS	DIAGNOSIS	TREATMENT
Vaginal Discharge .....187	Pelvic Adhesions, Endo-	Abdominal Hysterectomy...98
Pains in Abdomen & Sides, 117	metriosis, & P.I.D.....180	Supra-Vaginal ..... 4
Vaginal Bleeding .....108	R.V.O. with Cystocele	Perineorrhaphy Done
Swelling of Neck ..... 76	& Rectocele .....141	With Above .....80
Urinary Disturbances..... 49	Secondary Anemia .....103	D & C, Excision of Cer-
Fallen Womb ..... 39	Chronic Vaginitis and	vical Polyp and/ or
Breast Tumors ..... 24	Cervicitis ..... 91	Cauterization .....87
Sterility ..... 23	Fixed Retroversion, Etc... 69	Vaginal Hysterectomy &
Tilted Uterus & Backache, 20	Fibroids ..... 68	Ant & Post Colpor-
Irregular Periods ..... 17	Adenoma of Thyroid.... 64	rhaphy .....73
	Sterility ..... 47	D & C, Lap Pelvic, Ex-
	Ovarian Neoplasm ..... 40	cision of Endometrioi-
	Pregnancy ..... 39	sis and Suspension.....62
		Thyroidectomy .....56
		Cophorectomy .....37
		Bilateral ..... 6
		Salpingectomy and
		Appendectomy .....36
		Bilateral ..... 8
		Appendectomy .....32
		Excision of Breast Tumor..14
		Radical Breast Resection...13

## CHART I

The treatments of the organic lesions were carried out along accepted lines and the results obtained were comparable to accepted standards. There was no mortality in this group, and the complete end results are too detailed to analyze in this paper.

In Group II we again see a more indefinite group of complaints and even greater numbers and varieties, and here again the treatments cannot be specific, for many of the cases were predominantly functional with some organic lesions, that may have been the result, but probably not the cause of a multiplicity of symptoms. In some instances the organic findings could not produce the symptoms complained of, but it was used as an excuse for the symptom complex, just as rheumatism is used for all aches in the extremities, and any discomfort may be attributed to "high blood pressure," "low blood pressure," or "anemia," which are findings in most instances used as an excuse by the patient, which satisfies them or "saves their face." The endeavor should be to correct the functional condition, if possible, and then to have a better general condition, and this in time may help the organic condition. In many instances the functional condition causes a breakdown of the organic condition and this

can be corrected and the operation used as an excuse (an/or face saver), and a time to rest, relax, and build up the functional and general depletion, and in properly selected cases, excellent end results can be obtained. But this is only when the psychiatrist and surgeon discuss and collaborate to the fullest extent to bring about good results in these patients.

In Group III the complaints are twice as many and more vague and indefinite. The diagnoses and opinions are likewise non-committal. There were 2.9% of this group definitely psychotic, diagnosed so by a psychiatrist, and the remainder were an accumulation of the multiplicity of psychic and emotional maladaptations, and the resulting functional effects upon the organism in its attempt to cope with its environment. If we look at Groups II and III and study in detail the 464 cases we find that the majority were not sent by a doctor, but they had been to see a number of physicians and were shopping for a doctor to suit their ideas, or their families were grasping for straws, to settle the problem.

There were 310 cases that had predominant emotional symptoms with some organic findings, but the organic condition did not warrant surgical or much medical correction, and 154 were purely psychoso-

matic. One can then say that over 30% of the cases were on a purely psychosomatic basis, and that 46% were predominantly functional in nature. Breaking down the disposition of the whole group we have:

Surgical .....	536	53.6%
Medical .....	435	43.5%
Psychiatric .....	29	2.9%
Totals .....	1000	100.0%

Goal of Therapy

The goal of therapy is: (1) Symptomatic relief of the patient. (2) Show the patient what the cause of her complaints is, and have her share the responsibility in correcting it. (3) Improvement of the total functioning of the individual. (4) Prevent recurrences and complications by guidance, specific instructions, and cooperation.

In Groups II and III there is a definite

tendency to an increased number of previous operations. In this series 18% had had one or more operations, 2.8% had had more than three operations. Why do psychosomatic women undergo more operations than other women? The pre-existing gynecological symptoms from functional causes become exaggerated more easily with the onset of psychosomatic conditions, and then fixed with each menstrual period as an emotional change. As physicians, it is our responsibility to teach them to properly interpret their complaints and not encourage their neurosis by offering a course of shots to be used as an escape mechanism. The specialist is prone to appear too busy to find out what the emotional problem is. To put the patient off by stating, "that it is in her head," "nervousness," etc., and "to go home and forget it," cannot be done, for their complaints are genuine and sin-

GROUP II (310)		
COMPLAINTS	DIAGNOSIS	TREATMENT
Pains in Sides & Abdomen, 137	Physical Exhaustion .....113	Thyroid, Diet, Sedation....190
Backache .....106	Chronic Vaginitis (Anxiety) 83	Douches, Sedation .....153
Nervousness & Insomnia.. 93	Secondary Anemia..... 60	Rest, Sedation .....110
Stomach Trouble ..... 69	Hypothyroid ..... 34	Pessaries & Douches ..... 71
Tired, Feeling of Weight in Pelvis, Weight Loss.... 61	Hypotension ..... 26	Stilbestrol or Estrogens... 60
Weakness and Dizziness... 55	Anxiety Neurosis ..... 25	Face Facts of Life..... 32
General Ache in Extremities ..... 25	Hypertension ..... 24	Ptosis Belt & Exercise.... 15
Frequency, Burning, Itching ..... 22	Spastic Colon (Functional) 20	Rubins' Test ..... 10
Hot Flashes (Menopause).. 22	Exhaustion With Postural Backache ..... 20	Ovulation Studies ..... 9
Vaginal Bleeding ..... 19	Corpus Luteum Deficiency and Ovarian Failure.... 12	

CHART II

GROUP III (154)		
COMPLAINTS	DIAGNOSIS	TREATMENT
Pains in Side, Back and Abdomen .....133	Physical Exhaustion and Pelvic Congestion.....134	Referred to Psychiatrist .....33
Backacke ..... 86	Anxiety Neurosis..... 59	Endeavored to Explain Cause of Their Complaints to the Patient, and Referred Them Back to Their Family Physician when possible.
Depression ..... 78	Adult Maladjustment..... 48	
Fatigue ..... 78	Secondary Anemia ..... 46	
Frigidity ..... 77	Spastic Colon (Functional). 30	
Tired Feeling, Weight and Pressure in Abdomen... 74	Malnutrition ..... 20	
Stomach Trouble ..... 69	Psychosis ..... 19	
Nausea and Vomiting.... 40	Hysteria ..... 18	
Insomnia ..... 37	Hypertension ..... 10	
	Hypotension ..... 10	

CHART III



cere, and until we as doctors recognize this, we are neglecting the patient.

In 20% of the cases in Groups II and III, one can expect wonderful results, and most cooperative and appreciative patients; in the remainder of these groups, that are not terminated by an organic breakdown, they continue to seek a "face saving" providence of Hypochondriasis and continue the same mode of life, using excuses as escape mechanisms, and becoming deeper and deeper seated by the power of suggestion, habits, etc., aided by needless nostrums or surgery, until they become hopeless neurotics, chronic invalids, or psychotics.

What is needed is more good common horse sense, patience, sympathetic personal understanding, and personal interest in the case physically, psychologically, emotionally, and socially, and few will fail to appreciate it. Once the patient's confidence is obtained, then the building process starts, and good results can be obtained.

In this group 33 were sent to psychiatrists. More would have been sent but the public has not as yet learned to properly evaluate psychiatrists. The stigmata and

prolonged expense of psychiatrists are avoided by most patients. In some cases psychiatrists do not produce the desired results because these patients need stable examples to adjust to.

When we analyze the cases which have had previous operations, often those with emotional states, we find that the removal of organic trouble, when it was causing trouble, such as a thyroidectomy, removal of a kidney or gall bladder, breast tumors, etc., brought about for the most part considerable improvement, without any appreciable tendency to exaggerate the functional disorders.

The one group of operations such as chronic appendix, suspension of the uterus, and/or removal of ovarian cysts, either singly or combined, by and large were followed in the majority of cases by no improvement, and usually a progressive downward course physically and emotionally. Because these conditions were not the cause of the symptoms complained of by the patient, and it lowered the recuperative power of an already overloaded physical burden. "Remove the cause and the symptoms subside."

An analysis of 100 cases from the series

#### OPERATIONS PREVIOUS TO CONSULTATION

Appendectomy .....	195	
Oophorectomy .....	70	Bilateral..8
Hysterectomy .....	65	Vaginal...5
D & C, Cauterization .....	58	
Uterine Suspension .....	51	
Salpingectomy .....	45	Bilateral..4
Tonsillectomy .....	41	
Cystectomy (Ovarian) .....	22	
Fistula & Vaginal Tumor.....	20	
Removal of Breast Tumor....	15	
Operation for Adhesions.....	14	
Gall Bladder Operation.....	12	
Ant & Post Colporrhaphy....	11	
Thyroidectomy .....	11	
Caesarean Section .....	9	
Removal of Kidney Stone....	2	
TOTAL .....	641	

#### OPERATIONS AS A RESULT OF CONSULTATION

Abdominal Hysterectomy.....	98	Supra- Vaginal...4
Perineorrhaphy Done With Above .....	80	
D & C, Excision of Cervical Polyp and/ or Cauteriza- tion .....	87	
Vaginal Hysterectomy and Ant & Post Colporrhaphy..	73	
D & C, Lap Pelvic, Excision of Endometriosis & Suspen- sion .....	62	
Thyroidectomy .....	56	
Oophorectomy .....	37	Bilateral..6
Salpingectomy & Appendec- tomy .....	36	Bilateral..8
Appendectomy .....	32	
Excision of Breast Tumors...	14	
Radical Resection of Breast..	13	
Hernia Repair .....	10	
Ant & Post Repair and Ampu- tation of Cervical Stump...	9	
Sterility Studies .....	9	
TOTAL .....	536	

CHART IV

who have had appendectomies and/or tube and ovary and suspension, previous to examination, which made up 11% of the 1000 cases, and in 48% of the cases the symptoms existed before operation and in 60% of the cases it was made worse after the operation. Over 30% of these cases were getting series of shots without improvement. These cases averaged 28.3 years of age. Only 64% of them had children, with an average of 2.5 to a family, and 22% had had miscarriages. There was a range from 1-24 years from the time of operation, with an average of 8 years, and the majority of appendectomies alone were over 11 years. For all cases over 60% of the cases were within 3 years, and these were the ones who had the greatest disturbance after operation.

The average blood pressure was 118/74, of which 46% was 110/70 or less, and over 40% were elevated. Average age of beginning of menses was 13.2 years, of which 47% began later, and 35% were perpetually irregular. Only 19% of the cases reported dysmenorrhea.

#### Five Classes of Surgeons

It is noteworthy that these cases were operated on by five classes of surgeons:

- (1) The occasional operator.
- (2) The surgeon who believes that all pain and symptoms are produced by organic conditions.
- (3) Scapel acrobats with surgical training, and the desire for the acquisition of worldly goods.
- (4) The "too busy" doctor to take time to find the cause of the patient's trouble,

and as some have said, "If you operate and they don't die they have not been harmed."

(5) The doctor that is afraid of failure. Because so many patients seek surgery the doctor fears that if he does not operate, the patient will go elsewhere and be operated on.

The "operation for adhesions" in all those upon whom it was used, was destined to increase the psychosomatic complex, and in none of the cases studied did it help the condition or bring about a restoration of health, or improvement in health habits.

#### Method of Avoiding Operations

We can avoid many of these operations by:

(1) Not over-emphasizing unimportant abnormalities which have existed unrecognized for a long period of time.

(2) Recognition of emotional problems and explaining their relation and mode of production to their symptoms.

(3) Except in a few acute surgical conditions, acute appendix, ruptured viscus, volvulus, obstruction and strangulated hernia, etc., all selected surgery should be avoided until the emotional factors have been recognized and stabilized.

(4) Don't let unsuccessful surgery be an escape mechanism or substitution for facing the facts in life.

Not all will be ready to accept their own responsibility and work with you, but at least they do recognize the truth, see a new approach to their problem, and may

#### 100 CASES THAT HAD PREVIOUSLY HAD APPENDECTOMY AND/OR OOPHORECTOMY

COMPLAINTS	PHYSICAL FINDINGS	PREVIOUS OPERATIONS
Pain in Sides.....51%	Small Retroverted Uterus	Appendectomy Alone ....30%
Anorexia .....47%	With Pelvic Conges-	Appendectomy and
Insomnia .....43%	tion .....60%	Oophorectomy .....26%
Headaches .....39%	Hypopituitary Thyroid	Appendectomy, Ovary
Vaginal Discharge .....30%	Deficiency Syndrome..40%	and Tube .....23%
Nervousness .....26%	Secondary Anemia .....37%	Appendectomy and
Weakness and Tired	R.V.O. With Congested	Suspension .....21%
Feeling .....24%	Pelvis and Uterus ....34%	D & C .....13%
Backache .....21%	Cystic Ovaries .....13%	Hysterectomy and
Flooding Spell .....17%		Oophorectomy ..... 7%
		Bilateral
		Oophorectomy ..... 6%
		Presacral
		Sympathectomy ..... 5%
		Coccyxectomy ..... 5%

CHART V



later accept it. Thirsts are not always quenched by leading the thirsty to water.

Many afflictions of humanity are either disorders or distorted interpretations of sensory perceptions and not always a result of organic or structural pathology. We need when possible to teach the patients how to understand and interpret their symptoms correctly. No physician is immune from contact with true psychosis. The physician should know as much about the patient who has the disease, as he does about the disease that has the patient, so as to adequately treat them, and in our most refined specialization, never lose sight of the fact that we are treating individuals, even as you and I.

### Duty of Surgeon

Selective operations on women should never be done unless the following conditions are fulfilled.

(1) That the surgeon follow the patient for two years after the operation.

(2) That the symptoms complained of are caused by organic pathology, and when corrected will relieve the symptoms.

(3) That the benefits justify the risks taken.

(4) If you had the same condition would you be operated on for it?

### Summary

From this we cannot draw conclusions but we can awaken to a broader field of approach to human ailments, symptoms, and complaints, always trying to find and treat the causes of symptoms rather than treat the symptomology.

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### DISCUSSION

**R. A. Griswold, M. D., Louisville:** There are two things about Dr. Johnson's paper that especially interest me; first, he has gotten old enough to be philosophical and second, he has had a thousand patients.

When I was in the Service, I had two WAC induction centers under my supervision in the Fourth Service Command. The women who were in the WAC's represent a fair cross section of the women of the country. Many of them had been raised under completely different emotional and physical surroundings than they had after they got in the service. There were a great many menstrual irregularities, due to the change in the emotional and physical environment of these women. The Colonel, who was surgeon at one of the WAC Induction Centers, was a perfectly delightful older physician who had had little experience in gynecology, and the menstrual irregularities of his patients worried him no little; in fact, on one of my inspection trips he told me that "Between those that won't stop and those that won't start, they are driving me crazy."

Although it has been denied by many eminent authorities, it was well brought out by Dr. Johnson that emotional and physical environmental factors have a great deal to do with menstrual irregularity.

**The clinical and X-ray pictures of virus pneumonia** may at times be duplicated by early acute tuberculosis, and patients diagnosed as having virus infections should not be dismissed until the chest films are entirely clean. David T. Smith, M. D., Am. Rev. Tuberc. April, 1948.

the attainment of the highest standard of living in history have caused the virtual disappearance of tact, consideration, kindness, and common, ordinary, every-day courtesy? (Weekly Bulletin, St. Louis, Missouri Society, January 12, 1951).

We hear often of a "gentleman of the old school"—never of a gentleman of the new school. Is it because the new school does not provide for such a course in its curriculum? Why should the tempo of modern living have dissipated so many of the things that we have come to associate with past generations? Why should stupendous scientific achievements and

In the entire United States about 270,000 mental patients are coming back into the community each year. The spread of the disease from those who may have contracted tuberculosis while in mental hospitals therefore becomes a community problem which we cannot afford to ignore. Robert J. Anderson, M. D., Pub. Health Rep.

## SUMMERTIME MEDICAL EMERGENCIES

O. James Hurt, M. D.

BEDFORD

This paper has as its purpose a review of emergencies that tend to occur more frequently in summer. In the time allotted, this paper cannot be all inclusive. We must of necessity omit a discussion of conditions that many of you judge to be summer time emergencies. However, we hope to present a diversified group of conditions.

Probably, the first group of emergencies that come to mind are due to heat. One of the milder conditions, heat cramps, is the result of excessive loss of sodium chloride by sweating. These people respond to rest, cool environment, saline or salt tablets with ascorbic acid and manual pressure to the cramped muscles.

### Prostration

Heat prostration or exhaustion is more severe. It usually occurs in people working in hot, humid environments. The body heat is ordinarily dissipated by radiation, conduction and evaporation. As the atmosphere prevents or decreases the loss of body heat by these methods, the sweating increases as a compensatory mechanism. Gradually, this method becomes inadequate and results in an elevation of body temperature, dehydration and salt depletion. In the milder form, there is restlessness, headache, throbbing, dizziness, dyspnea, tachycardia and diminished sweating. The body temperature will probably be 102-103° F. Later, there may be collapse with weakness, dilatation of pupils, weak pulse, cold clammy skin and elevation of rectal temperature. The milder form responds to rest, cooler surroundings, water, salt and ascorbic acid. The more severe form may require massage and saline infusions.

A more severe reaction to heat is heat stroke, which is characterized by sudden collapse; rapid, extreme rise in body temperature; dry, hot skin; rapid pulse and deep, labored respiration. There may be flaccidity or twitchings and spasms of the muscles. Temperatures above 108 F. are not considered compatible with recovery. There is a high mortality and treatment must be prompt and even heroic.

### Treatment

Reduce the fever rapidly, use cold applications, fans, and cold enemas. Massage the skin to maintain circulation. It may be necessary to give artificial respiration with oxygen due to spasms of the diaphragm. Discontinue the reduction of temperature at 102 F., at which time an infusion of 5% glucose in normal saline with 500 mgm of ascorbic acid may be started. Too, efforts should be made to combat liver damage. We have not seen a report of ACTH being used, but we are interested in what the results might be.

### Motion Sickness

With summertime and increased traveling, we are many times confronted with motion sickness. This is not an emergency of life and death, but it can ruin what is otherwise a very pleasant vacation. Dramamine has become the travelers friend. The recommended dosage is 50-100 mgm 10-15 minutes before exposure, then 50-100 mgm every 4 to 5 hours, p. r. n. If the patient is already vomiting, the medication may be given in 30 c. c. of normal saline rectally. A child 5 to 10 years of age would receive 25 mgm two or three times daily. Do not give Dramamine to the driver; it may cause sleepiness.

### Drowning

Drowning requires rapid action with perseverance. Place the patient in the prone position with his head lower than the thorax. Check frequently to maintain a free airway. Loosen the clothing and keep him warm. Maintain artificial respiration with oxygen if possible until normal respiration is attained or rigor mortis begins. Give a respiratory stimulant intravenously. If the patient responds, give him antibiotics to prevent pneumonia.

### Insect Bites

The bites of insects and snakes constitute a large percentage of our summertime medical emergencies. The sting of a bee, wasp, or hornet may be serious or even fatal. This is especially true if there are multiple stings or if a small child has been stung.

Apply soda bicarbonate or an antihista-



minic ointment locally with ice packs. Give an antihistaminic parenterally. Bee antivenin may be used if it is available.

### Black Widow Spider Bites

Another insect that is becoming more and more important because of its increasing number is the Black Widow Spider. At one time most of the bites occurred in out-buildings. Now, increasingly more bites are received at other places.

The bite of the spider is the first stage. There is a sharp, stinging, needle like pinch accompanied by a burning sensation. The second stage, the stage of vascular dissemination, usually begins about ½ hour after the bite, spreading to the chest and abdomen. The abdomen becomes rigid with cramps. Respiration is labored and there is an expiratory grunt. The pulse rate, slow and weak at first, becomes more rapid as the blood pressure first falls, then rises. There is profuse perspiration, normal temperature, tremors of hands and fingers, urinary retention, constipation and no point tenderness or localizing pain. The third stage is the stage of elimination. At this time there is burning of the soles of the feet.

### Treatment

Treatment is the intravenous administration of 10 c. c of 10% calcium gluconate. Antivenin may be used, but is usually not available.

### Snake Bites

The seriousness of the snake bite has been exaggerated. The important thing is the size of the snake and the size of the victim. We have four poisonous snakes in the United States, the rattlesnake, copperhead, cotton mouth moccasin, and coral snake. They produce two toxins, neurotoxin and hemotoxin. The coral snake produces mostly neurotoxin which affects the respiratory center. The others produce mostly hemotoxin which causes hemolysis of erythrocytes, extravasation of blood, local destruction of tissue and extreme edema with subsequent weakness, vertigo, tachycardia, and irregular or weak pulse.

### Treatment

Treatment is directed at preventing the absorption of the toxins. Apply a tourniquet tight enough to stop the venous and lymphatic flow but not the arterial. Cut cruciate incisions at the fang marks to their depth and apply suction. Make more incisions as local swellings develop. Wash

with sterile or clean water often. Avoid potassium permanganate crystals or other cauterizing agents as they are of no value and further damage the tissues. Give antivenin as soon as possible. The dose is 15 c.c. - 75 c.c. Begin by infiltrating about the site of injury and inject the rest intramuscularly or intravenously. Be sure to give a large enough dose. Children frequently require more than adults. Transfuse with whole blood as the need arises.

### Acute Diarrhea

Acute diarrhea is not only incapacitating but may have serious consequences in children. A severe diarrhea, which may be accompanied with vomiting, rapidly dehydrates the patient and readily upsets the electrolyte balance in younger children. Prompt action is necessary. Pyridoxine and thiamine will usually control the vomiting so that medicine can be taken orally. Until vomiting has ceased, only parenteral medication can be given, such as 5% glucose in normal saline, penicillin and codeine or morphine for pain. Ordinarily, purgatives and enemas are contraindicated. When the patient can tolerate medicine orally, begin a kaolin-pectin compound and a sulfa, usually sulfadiazine. Restrict food except fluids for 18-24 hours. Since it is difficult and impractical to obtain cultures, the diarrheas that do not respond to sulfa and penicillin should be tried on aureomycin or chloromycetin. If there is no response to these drugs, then there should be a search for a specific etiological agent such as endamoeba histolytica, shigella, salmonella or one of the others.

### Conclusion

In conclusion, may we remind you that to be constantly aware of these summertime medical emergencies, enables you to meet their needs more readily and adequately.

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**Addendum At Request of Dr. Overstreet**

What I think Should Be In The Emergency  
Bag Of A Rural Practitioner

**Instruments and supplies**

Stethoscope  
Sphygmomanometer  
Otoscope  
Thermometer  
Percussion Hammer  
Tourniquet  
10 cc syringe with 22 needle in sterile container  
2-cc syringes with 25 needles in sterile container  
2-2cc syringes with 20 needles in sterile container  
Bandage scissors  
Adhesive tape 1" or 2"  
Sterile Gauze pads 3" x 3"  
Bandage 1", 2", 3"  
Sterile rubber gloves  
Flash light  
Prescription pad  
Antiseptic solution-aqueous and tincture  
Lubricating jelly  
Ampul file  
Pill envelopes  
Aromatic spirits of ammonia

**Narcotics**

Morphine-sterile solution, 15 mgm/cc  
Morphine-atropine solution, 15 mgm-0.40 mgm/cc  
Methadon-sterile solution, 10 mgm/cc  
Codeine-sterile solution, 30 mgm/cc  
Morphine tablets, 15 mgm  
Codeine-30 mgm with A. P. C.

**Ampuls or Vials**

Adrenalin-aqueous, 1:1000  
Adrenalin in oil, 1:500  
Coramine and/or metrazol

Digitoxin  
Ergotamine tartrate or dihydroergotamine tartrate  
Ergotrate  
Pituitrin and/or pitocin  
Prostigmin  
Mercurial diuretic  
Aminophyllin or similar product  
Calcium gluconate, 10 cc of 10%  
Sodium amytal, 0.5 gm.  
Sodium phenobarbital, 0.3 gm.  
Vitamin K  
Pyridoxine  
Depropanex  
Testosterone, 50 mgm/cc  
Estrogenic 2 mgm/cc  
Progesterone 25 mgm/cc  
Antihistaminic  
BAL.  
Penicillin-300,000 units procaine with 100,000 units crystalline/c  
Magnesium sulfate, anhydrous, 10% w/w  
Water for injection

**Tablets or Capsules**

APC-adult and children  
Phenobarbital, 15 mgm and 30 mgm  
Pentobarbital, 0.09 gm  
Antispasmodic  
Ammonium chloride, 0.5 gm enteric coated  
Calcium iodide 0.06 gm  
Sulfa  
Calcium carbonate 0.6 gm  
Antihistaminic  
Quinidine sulfate 0.3 gm  
Amphogel  
Aminophyllin or similar product  
Digitoxin  
Ergotrate  
Atropine sulfate, 0.4 mgm  
Nitroglycerine, sublingual, 0.4 mgm

**Tuberculosis has long been considered in** that class of diseases not exhibiting to any extent epidemic waves, but having, instead, a high endemic incidence. However, in communities where the incidence now has dropped to relatively low levels, we are becoming more and more aware of explosive outbreaks of tuberculosis. The previous, relatively constant level of endemicity we now realize was merely the closely grouped climaxes of myraids of epidemics producing the illusion of a smooth curve. It is the difference between being unable to see clear-cut patterns of waves in a pool of water when one peppers the surface with dozens of pebbles, and seeing only one

clear pattern after dropping one pebble on a mirror-like surface. Tomorrow's Horizon in Pub. Health, James E. Perkins, M. D., Tr. 1950 Conf. Pub. Health A. New York City.

**Few diseases have shown the continuous,** yearly decline in mortality exhibited by tuberculosis. Mortality from tuberculosis continued to decline in 1949, when 39,000 deaths from all forms of the disease occurred in continental United States. The death rate is estimated to be 26.2 per 100,000 population, excluding the armed forces overseas. Evelyn H. Halpin and Otis D. Turner, Pub. Health Rep., May 4, 1951.



## AN APPROACH TO THE PROBLEM OF GASTRIC ULCER OR GASTRIC CANCER

James E. Hix, M. D.

OWENSBORO

A discussion of the approach to the problem of gastric ulcer or gastric malignancy is justifiable because of the notable lack of progress in reducing the death rate from carcinoma of the stomach despite many developments within the past two decades which would be expected to give a better prognosis. It is my intent to present a point of view which is by no means original, being accepted surgical teaching in several clinics, but which as yet is not generally accepted by the profession.

### Morbidity and Mortality Rates

Just how important is carcinoma of the stomach? It is well known that cancer ranks second only to cardiac-vascular disease as a cause of death in the United States, but it is not so well appreciated that carcinoma of the stomach causes from 20-25% of these deaths. It has been predicted that this year there will be over 200,000 deaths from cancer, and carcinoma of the stomach will account for approximately 40,000 of these deaths. It has been forcefully brought home by Engle (1), in less time than I have been allotted for this presentation, two persons will have died in this country of carcinoma of the stomach. As the age of the population increases, it logically follows that the cancer problem will increase. Carcinoma of the stomach, being one of the "hidden" cancers, will unfortunately have a large share in this increase unless a far more aggressive attitude is adopted by all concerned. In 1939 Livingston and Pack (2) wrote the following: "There are more deaths from cancer of the stomach than from all malignant tumors of the lip, tongue, cheek, tonsil, pharynx, larynx, salivary gland, thyroid, male and female breast, ovary, uterine cervix and corpus uteri combined."

As one talks with physicians one cannot help but be impressed with the note of pessimism. As one looks into the literature one finds reason for concern in reviewing those series in which the diagnosis of carcinoma of the stomach is definitely

established preoperatively. Welch and Allen (3) in reviewing the admissions to the Mass. Gen. Hosp. for the period 1937 to 1946 inclusive report a 5 year survival rate of about 7%. Significantly, the 5 year survival rate for the period 1927 to 1936 inclusive was about 5%. Abrahamson and Hinton (4) report a 5% five year survival rate and proposed mass fluoroscopy as one means of early detection.

### Tragedy of Delayed Surgical Treatment

Another point of particular interest in the informative review by Welch and Allen (3) concerns the delay in seeking surgical treatment. When the delay curves were plotted for the two ten year periods it was found that they practically coincided. The implications are obvious. To be sure there will be seen cases that will be inoperable though there be minimum delay by both patient and physician. Too frequently, however, culpability for delay has rested upon the physician. Anglem (5), in studying this question in presumably a representative community in Massachusetts, found that in 127 cases the patient was responsible for an average delay of nine months whereas in 72 cases the physician was responsible for an average delay of 17 months. Maimon and Palmer (6) have recently noted a trend toward earlier diagnosis, but the delay is still too great to appreciably alter the death rate.

While the number of cases seen within the past year by my associates, Drs. L. C. Dodson and H. J. Davis, and myself is so small that it is of no statistical significance, it is significant that no case was seen in which the operation for cure could be carried out. It is further significant that in the two hospitals in Owensboro only palliative procedures have been done within the past year. We must admit that the picture is indeed dark when one can make the clinical diagnosis of carcinoma of the stomach, or when the roentgenologist unreservedly makes the diagnosis of malignancy of the stomach. Regardless of the causes of delay, the disease in these instances must usually be considered advanced and hope of cure is small.

Let us leave for the moment the gloomy picture and turn to one in which the surgeon is considerably more successful. Without regard for the moment of the indications, what can be expected of an adequate, properly executed gastric resection for gastric ulcers?

### Results of Early Operation

Ransom (7), St. John (8) et al and Marshall and Welch (9) have recently reported followup studies which, although there are minor statistical variations, are in sufficient agreement that certain generalizations may be permitted. I think we can safely say that excellent results may be obtained in from 65-70% of the patients having gastric resection. By excellent results is meant complete return to normal without restrictions of any type. In another 20-25% the results are satisfactory in that there will be no doubt in the patient's mind that he is far better by virtue of his operation, but there will be minor complaints of one type or another which for the most part are easily controlled. In 90% then, or better, satisfactory results will be obtained, a figure which should weigh considerably in approaching this problem. Certainly there is a small percent who will not be benefited. I know of no way to eliminate these.

### Present Mortality Rates

Then, there must be an inevitable mortality rate. However, the physician who thinks in terms of mortality rates of two decades ago must revise his thinking in determining what is best for a given patient. Operative mortality rates of 3.0% or better in recent years are frequent, and there is more than one report of a sizable series (90-120 cases) without a fatality (10), (11), (12). The reasons for the improved mortality rates are several and beyond the scope of this paper. I believe that the present mortality rate should be under 2.5% or else the surgeon should critically review his judgment or technique. It would seem fair to say that the surgeon can very successfully treat gastric ulcers with a creditable mortality rate and in those patients with an established ulcer diathesis is more successful over a five year period than is our medical colleague.

You have just heard Dr. Palmer discuss the treatment of peptic ulcer. The indications for surgery in duodenal ulcer are fairly clearcut and generally accepted. But to fail to differentiate between gastric

and duodenal ulcer is a serious mistake. The incidence of primary duodenal malignancy is so low that it need not be considered in the list of surgical indications. This is not so in gastric ulcer. Without intending to enter into any pathological controversies, I am certain that carcinoma of the stomach can and does arise in peptic ulcerations. The evidence to me is clearcut and conclusive.

### Diagnostic Errors

Is it possible to differentiate between the ulcer which is benign and the ulcer which is malignant? May I review the findings of authors who have had considerable experience with this problem. Allen and Welch (3) found carcinoma in 14% of 277 cases diagnosed as ulcer. Stewart (13) found carcinoma in 23.6% of his cases of gastric ulceration not diagnosed preoperatively. Marshall and Welch (9) report a diagnostic error of 19.8%. Judd and Priestly (14) report a diagnostic error of approximately 10% from the Mayo Clinic. Ransom (7) states that in 10.1% of his cases the findings at operation were such that the usual operation for ulcer was carried out and yet the pathologist reported malignancy from the microscopic sections.

### Uncertainty of Diagnosis

The clinics above undoubtedly have access to the best of diagnostic facilities. Research is constantly in progress in an attempt to simplify this problem, but as yet we do not have the answer. For the present with the best in roentgenography, endoscopy, cytological studies or clinical laboratory studies, there is an error of such proportion that it seems to me it's time we admit that we cannot make the differential diagnosis with any degree of certainty in time to materially influence the five year survival rates of carcinoma of the stomach. Dr. Marshall in dealing with this question at the Cancer Symposium in this city last year summarized the answer by a shrug of the shoulders and the question "who can tell?"

### Various Factors Influencing Diagnosis

There are other factors which influence a given decision such as age or the location of the lesion. We know that lesions on the greater curvature, the prepyloric areas or in the cardia are more apt to be malignant than the lesion on the lesser curvature or the lesion on the anterior or posterior walls. But how futile it is to at-



tempt to decide upon the management of a particular case on the basis of location of the lesion, age, size of the lesion, or any other diagnostic criterion, when we know that there is conservatively at least a 10% chance of being wrong, that at least one of every ten patients diagnosed and treated as benign gastric ulcer will have gastric carcinoma.

### Value of X-Ray

I have assumed that no physician will fail to obtain x-ray studies on the patient in the cancer age group who presents himself because of some vague epigastric disturbance, anorexia, perhaps loss of appetite for meat or any symptom directing attention to the G. I. tract, for the roentgenologist is easily the "front line" in demonstrating the presence of gastric lesions. Having located the lesion in the stomach, the physician who for whatever reason decides to treat it as a benign lesion, must realize that he accepts a grave responsibility.

### Improvement in Survival Rate

The improvement in the five year survival rate for gastric carcinoma operated upon at this time rather than waiting for signs or symptoms establishing the diagnosis beyond reasonable doubt is very significant. Welch and Allen (3) in their excellent followup study state that the five year cure rate in those cases clinically indistinguishable is at least 40%. Ransom (7) had 41.2% five year survivals in those patients having the standard ulcer operation, but pathologically having carcinoma. These figures are to be compared with the previously mentioned 5-7% five year survivals.

### Conclusions

From the foregoing certain conclusions may be drawn which as stated are by no means original but need to be reemphasized.

1. In the cancer age group gastric ulcer is primarily a surgical disease.

2. The differential diagnosis between gastric ulcer and early gastric carcinoma is difficult and often impossible, there being a definite irreducible error by present diagnostic methods.

3. Immediate surgery is recommended for those patients in the cancer age group who have greater curvature, prepyloric or lesions in the cardia.

4. A strict medical regime is recommended for those patients having lesions located elsewhere in the stomach, or for patients in the precancer age group. If at the end of four weeks there is not complete healing, surgery is then the treatment of choice.

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### DISCUSSION

**Jack G. Webb, M. D., Lexington:** When I was invited to discuss this paper I hoped sincerely that Dr. Hix would say many things with which I could disagree, since the easiest way to discuss a paper is to tear it apart, but I find that all I can do is agree with all of his points and attempt to reemphasize some of them.

I find myself in disagreement with the opinion expressed by Dr. Palmer when he said that gastric ulcers could be handled safely in many cases on a medical regime. Gastric ulcer is a surgical lesion and the only safe way to treat it is by subtotal gastric resection. Walters and many others have repeatedly pointed out that not only do roentgenologists and surgeons err in their opinions as to the benign or malignant nature of an ulcer, but the pathologist has a rather poor batting average on frozen sections. The only safe place for a gastric ulcer is in the

(Continued on Page 455)

## PRACTICAL ASPECTS OF CHRONIC PROSTATITIS

Douglas E. Scott, M. B., M. S. (Urol.)

LEXINGTON

My selection of this topic for presentation was assuredly not due to any element of drama—either in the disease or its treatment. In fact the disease lacks so much in, shall I say, *personality* that it is easy to understand its neglect by those of us dealing with all the other interesting ailments of mankind. Symptoms are so often vague, treatment so necessarily persistent that it is one of the more easily and I sometimes suspect, willingly disregarded diseases.

Yet I feel satisfied with the correctness of Hinman's estimate that 35% of all adult males have chronically infected prostates. It follows then that unless your practice is limited to disorders of the female or of children there are patients in your office daily with chronic prostatitis. It is also apparent that there are not enough urologists to treat 35% of the male population. There is need then for a good working understanding of the disorder by general physicians and other groups of our profession.

If your experience was like mine I doubt that you can recall anything you were taught of chronic prostatitis at school. During interne days you were unaware of chronic prostate infection because it is not a disease ordinarily requiring hospitalization. Since you began practice very little in available medical literature has appeared to acquaint you with the disease.

### Symptoms

Suppose then we approach the disease as we must in practice, considering symptoms that are presented.

First of all this must be said. Patients with prostatitis may have symptoms without having complaints. Symptoms of long standing may come to be accepted as the normal way of life and so be overlooked by the physician as well as the patient unless direct questioning is used.

Symptoms of prostatitis group themselves into three general classes. First, the kind commonly attributable to any focal infection; second, local symptoms that express themselves directly in the

prostate or contiguous structures; third, sexual disorders.

Prominent among the focal symptoms is listlessness that comes from general toxemia. It may be very heavy or be so slight that it is one of the unrecognized symptoms. Arthritis, myositis, neuritis, are common presenting disorders. Acute iritis has quite commonly its source in a chronically infected and otherwise "silent" prostate.

A very common complaint due to prostatitis is of pain in the low lumbar and sacral area. These pains are achy, persistent and often are described as extending down the backs of the thighs or around the pelvic girdle to groins, lower abdomen, retropubic region and scrotum. Sometimes severe and disabling, these pains are just as often vague, indefinite discomforts.

Local symptoms of the disease may be pain complained of in the rectum or prostate itself; a sense of fullness in the prostate region, perineal, urethral and penile aches. Such discomforts are usually aggravated by hard chairs. A mild urethral discharge is common and frequency and urgency of urination can be understood from the location of the prostate at the neck of the bladder and surrounding the first portion of the urethra.

Sexual disturbances will be encountered as premature ejaculations or a relative degree of impotence. Interestingly this seems the least common of the complaints.

Such patients can be restless, nervous, unable to concentrate and develop anxiety states which in turn lead to gastro-intestinal disorders—flatulence, constipation, anorexia and so on.

All combinations of the above disturbances will, of course, be met. It must be apparent, however, that individually the symptoms described are of types that could have many other origins. So differential diagnosis extends to a wide range of diseases. Neurosis, chronic or acute appendicitis, diverticulitis, gonorrhea, urinary tract disorders of almost all types, prostatic hypertrophy, malignancy and tuberculosis, all the dozens of causes of low back pain not excluding the dis-



placed intervertebral disc may have to be considered in one case or another.

### Pathology

The pathological process producing these symptoms will be understood when one considers the structure of the prostate itself. You will recall that the prostate has some forty to sixty ducts which open into the posterior urethra and which are too small to see without magnification. These ducts lead from tortuous branching gland systems imbedded in a fibromuscular stroma. It is easy to see that bacteria can invade such a structure easily and escape it with difficulty. When it occurs polymorphs and cellular debris accumulate in the acini. Lymphocytes invade the stroma of the gland. With time the reaction to bacteria results in scar tissue. Contraction of scar tissue obliterates some acini, closes ducts and distends other acini, impairs circulation and in general destroys the normal architecture of the gland. Finally contracture of the whole bladder neck and posterior urethra may result.

### Etiology

I will not need to go deeply into the etiology of this disease. The types of bacteria, their several sources and routes to the prostate you can deduce. Some comments, however, seem necessary. In addition to the commonly thought of focal origins of bacteria certain other sources should not be forgotten. Acute respiratory infection is one not uncommon source for the bacteria which invade the prostate. The backache persisting too long after flu may mean an infected prostate. Skin infections should not be forgotten as a possible source. Gonorrhea on the contrary can no longer be considered more than an occasional instigator of chronic prostate infection.

The types of bacteria involved may be mixed. Frequently, however, no bacteria can be stained or cultured from quite badly infected prostates.

I think there is good reason to believe that the initial invasion by bacteria is not characterized by an acute severe reaction in the gland. That is, chronic prostatitis does not commonly commence as acute disease.

It is my observation that acute prostatitis is most often an exacerbation of an infection long manifest. There are frequently found quite badly infected pros-

tates which have never caused local symptoms as an acute infection surely must.

Contributing factors in the etiology are of very real importance. They are those conditions which create or maintain vascular congestion in the gland. Such factors are heavy lifting and long automobile trips. Alcohol and poor sexual hygiene are two principal influences of this kind. By poor sexual hygiene is meant here those practices which tend to prolong sexual excitement beyond its normal reflex course.

### Rectal Examination of the Prostate

The prostate is readily accessible for rectal palpation. It is situated in front of the rectum, the apex of its triangular posterior surface just inside the internal rectal sphincter. For the best examination the patient is placed in an extreme stooping position. The well lubricated gloved index finger is inserted slowly and gently through the anal sphincter into the rectum until the top margin of the prostate is felt. The gland is then first examined without pressure.

The average normal prostate felt in this way has an area on each side of the midline approximately that of the distal phalanx of your thumb. In the midline there is usually a shallow sulcus. The gland should have a well defined margin, be symmetrical, its surface smooth, uniform, of rubbery consistency. It should not be rigidly fixed in position nor more than moderately sensitive to small pressure.

The infected gland may be slightly larger than normal, softer, almost "boggy." Its structure may have an irregular consistency—indurated in some areas, soft in others. This may at times suggest the presence of prostatic stones, tuberculosis or malignancy. Such possibilities, of course, demand active investigation and can not just be left for time to clarify.

Infection sometimes thickens surrounding structures obscuring the margins of the gland and giving it abnormal fixation. In long standing infections the gland may be unusually small and with a uniform firmness that indicates extensive fibrosis. All of these variations represent phases of the disease process.

It must be remembered, however, that a prostate that feels perfectly normal can still be quite badly infected. Palpation alone is unreliable for diagnosis.

So the next step is to express secretion for microscopic examination. A microscope incidentally is one piece of equipment essential to the diagnosis and treatment of this condition. The patient can conveniently hold a cup under the penis to catch the fluid as it is expressed by massage. Let that first massage be gentle even if no secretion is obtained. Gaining the patient's confidence may be more important than finding out at once all you would like to know. He is going to have to return for repetition of the examination in any case, and there is always the possibility, until you get acquainted with a prostate, of causing an exacerbation of symptoms by too vigorous massage.

Massage will best be carried out by bringing the flat tip of the index finger evenly and slowly straight downward from the top margin of the prostate along one outer edge. Then return the finger to the top margin and stroke down again just medial to the area first covered. A third such stroke just beside the midline will complete one side. Repeat this procedure on the other side. Stay away from the midline except for the final stroke. There is a nerve center here where pressure causes most discomfort. This final stroke should strip the posterior urethra of secretions expressed into it.

Where secretion is persistently scant or viscid the passage of an urethral sound will sometimes help open up blocked prostatic ducts.

Some of the secretion is now placed on a glass slide under a cover slip and examined microscopically. The physician will find himself more closely in touch with the condition if he does this himself rather than relying on a report from his laboratory.

The number of white blood cells seen under the microscope will be a measure of the degree of infection. Above ten pus cells per high power field is getting into the abnormal range. Clumping of pus cells indicates stasis in the gland system. On the first examination secretion from a badly infected prostate may appear perfectly normal. Two or three massages at intervals of two or three days may be required to demonstrate how much infection is really present.

### Treatment

Many forms of treatment of the disease have been tried and given up. Some should be mentioned because questions are still

being asked about them. Twenty years ago foreign protein injections had a vogue. Ineffectiveness led to their abandonment. Autogenous vaccines have been thoroughly tried and discarded. Direct injections into the gland of antiseptics through a long perineal needle seemed to this writer a poor idea to begin with and certainly resulted in some fibrotic, very troublesome glands. Local heat whether in the form of diathermy, the Elliott machine, patent electric appliance or just hot rectal irrigations with an enema bag is not of importance in the treatment of the chronic phase of prostatitis.

A regular uninterrupted course of prostatic massage remains the most effective therapeutic measure. It has a double purpose—to establish and maintain drainage in duct systems that have been blocked by the products of inflammation and to improve circulation and so aid natural recovery processes.

Secretion, of course, must be expressed if proper drainage of the gland is to be effected. There is an optimum pressure to accomplish this. While for reasons mentioned the first few treatments will be gentle, firmer massage can be carried out as treatments progress.

As part of the treatment the two seminal vesicles immediately above the prostate should if possible be reached with the finger and stripped until their freedom from involvement is established. Normal seminal vesicles are either not palpable or barely palpable structures.

From thoroughly fibrosed prostates no secretion may be obtainable. However, clinical improvement will many times result from firm massage of these fibrous glands.

There is commonly with prostatic infections an associated congestion of the posterior or prostatic portion of the urethra. The instillation of mild silver salts into this portion of the urethra with a catheter and gentle passage of steel sounds of as large a calibre as the urethral meatus will accept will give surprising relief of some local symptoms which massages alone do not eradicate.

There is an optimum interval for treatment. Daily treatments will aggravate rather than help the infection. At a seven day interval ground gained is likely to be lost. An interval of two to four days seems to accomplish best results.

Treatment should be continued until



pus no longer shows microscopically in the secretion obtained. In many glands irreparably damaged by infection this result is unobtainable. When, however, the best possible has been attained as shown by microscope and the patient is symptom free, treatment should then be discontinued gradually. That is, the interval between treatments should be lengthened and the patient so followed over a year.

You will do well to have your patient understand at the outset that treatment must go beyond mere symptomatic relief and must persist without interruption to the best possible microscopic appearance of the prostate secretion. It will usually take a minimum of sixteen to twenty treatments to reach a self-sustaining level of improvement. Long before this, however, symptoms should be relieved.

I definitely do not subscribe the school of reasoning that recommends sexual intercourse as a therapeutic procedure. It is entirely unlikely to be undertaken with that end in view by the patient and such a prescription in any case carries certain peculiar hazards of its own. The argument is, of course, that a natural emptying of the prostate should be more complete and efficient than mechanical evacuation by massage. While this may be true of a normal uninfected prostate I do not believe it true of the diseased gland. Infected tubules, obstructed and distended and surrounded by fibrous where there should be muscular tissue just does not empty unless by mechanical pressure. Moreover massage is carried out without the congestion that accompanies sexual reflexes.

I have spent much time on the matter of prostatic massage because I think it a widely misunderstood procedure. Massaging of the prostate, however, is not the beginning and the end of treatment. It will fail of its purpose if attention is not given to the elimination of all possible contributing factors.

Urethral strictures must be looked for and corrected. The vicious circle of infection between the prostate and the urinary passages must be anticipated and both phases of such combined disease attacked.

Focal infections elsewhere must receive consideration. Constipation must be corrected. The congesting effects of alcohol and of disorderly sex practices must be understood by the patient. It can be said,

however, that normal intercourse allowed to run a normal reflex course and not prolonged at least is not harmful.

Occupations that involve heavy lifting, long automobile trips and motorcycle riding should be considered hazardous and contributing factors both by the patient and any insurance company.

Our new bacteria destroying drugs, the sulfas and molds, seem to bring only transient improvement to prostate infections. The agents are selective in action and may not cover the mixed bacterial types present. In vitro sensitivity tests have been tried but even then the results are indifferent. This should not be surprising when one considers the damaged, distorted, debris filled ducts so suited to the harboring of bacteria. The only time I think that these new agents could be expected to be very helpful is early in the disease before scarring has taken place.

#### Effects of Treatment

Complete symptomatic relief occurs in such a high percentage under treatment that it is almost to be expected. The phenomenon of immediate relief of some complaints following a single prostatic massage has been seen so often that it would seem to imply that certain symptoms ordinarily considered of toxic origin must surely be reflex in character arising from prostatic congestion. Cures undoubtedly are obtained. I cannot help but question statistical reports of percentages of cures. When one considers the structure of the gland, and the permanent damage done to it by infection, and the susceptibility of this damaged structure to re-infection it would seem wiser to regard any infection as arrested rather than cured.

The effectiveness of treatment will rest on these things:

1. The correctness of your method of prostatic massage.
2. The degree of fibrosis that has occurred in the gland. This you cannot influence.
3. The patient's co-operation in eliminating bacterial foci and his ability to change contributory hygienic working and living habits.
4. The maintenance of the patient's interest beyond symptomatic relief until the greatest possible improvement in the prostate can be attained.

## DISCUSSION

**H. E. Martin, Ashland:** Our essayist has so completely covered the subject of chronic prostatitis that there is little to add except possibly some emphasis on a few of the important clinical aspects of this condition. As one of our colleagues has put it, "the clinical importance of chronic prostatitis lies in its prevalence and in its peculiar tendency to persist, unless adequately treated." Frequently this condition is a silent malady and exists for many years without being diagnosed. As has been mentioned, gonorrhea comprises only a very small percentage of the infections and currently with the molds, and sulfonamides, practically none. One of the first attentions should be directed to adequate drainage of the lower urinary tract. A simple inspection of the urethral meatus may elicit an obstruction which may be a causative factor of the infection as well as retard progress of the treatment. Urethral strictures and residual urine should be excluded as possible factors in the cause of the infection. Even though it is not commonly the case that bacteria become transplanted from the urethra to the prostate, this does occur when an infected urine from the bladder or upper urinary tract flows over the prostate. This should be given some attention when a prostatitis does not respond to a prescribed course of treatment and other factors have been eliminated.

It should be remembered that the feel of the prostate gland, rectally, is not any accurate criteria as to whether or not it is infected. Microscopic examination of the prostatic secretion becomes imperative if one is to learn the real truth. Apparently in focal infective prostatitis, the entire gland is not always involved and if the infected follicles are not emptied by diagnostic massage, one may obtain only the secretion from healthy follicles and conclude the gland is normal. Hence, the reason for a second or third study of the secretion within a few days of each other. If infection is found after the second or third massage, it is confirmatory evidence that there is a deep seated prostatic infection, because massage, repeated a number of times, does not cause the appearance of pus in the secretion. The presence of lecithin crystals in the prostatic secretion has some prognostic value, being diminished or absent with the presence of many pus cells in the secretion and returning as the infection improves.

Treatment of prostatitis revolves around the principles of drainage of the infected prostatic ducts. Sometimes this is easily accomplished but usually more difficult when sclerotic changes are present. Dr. Scott has given us very explicit details as to how this massage should be done and I merely want to place emphasis on gentleness and avoidance of trauma. I usually massage these cases at five (5) day intervals for a period from two to three months, depending upon the progress of the infection. Chemotherapy has not been of any special benefit except in acute exacerbations of a so-called urethro-trigonitis, associated with marked vesical distress. Penicillin has been of no value in chronic prostatitis in my experience; however, gantrisin has been effective in some of the more suppurative processes.

Patients get some reaction during the course of treatment of a focal infective prostatitis. As a rule, these reactions occur to patients with ocular diseases, commonly iritis and keratitis, arthritis and myocarditis. As a rule these reactions follow prostatic manipulation within 12 to 24 hours. Chills and fever may result but more commonly, there is an increase in the patient's symptoms of pain in the eye, or the joint symptoms become aggravated. Some consider these reactions of diagnostic significance, namely that their occurrence after prostatic massage is proof that the prostate is a factor in the focal symptoms; that they occur in the majority of eye cases and in 50% of the arthritic cases, in which the prostatic infection is a factor. Prostatic massage should be exceptionally mild when done to a patient with an active lesion of this type until a tolerance has been established. In case of a reaction, the massage should be discontinued for three or more days after complete disappearance of the symptoms.

Another not uncommon complication of chronic prostatitis is that of non-specific epididymitis. Most of these epididymitis cases are associated with infections of the prostate and either follow massage, instrumentation, or urethral injections. An acute epididymitis, frequently, is the first subjective evidence that the patient has any urinary tract infection. After conservative management of bed rest, elevation and possibly some of the antibiotics, and the epididymitis has subsided, a check of the prostate and secretion should be done to uncover a possible cause of the infection.



## ABDOMINAL TRAUMA

R. W. Robertson, M. D.

PADUCAH

Interest in the subject of abdominal trauma was greatly stimulated by the experience of the last World War and there has been more written about injuries of this type during the past ten years, than was written in the twenty or maybe fifty previous years. The largest number of abdominal injuries ever reported came from this war with a mortality rate much lower than ever before had been reported in any previous military conflict. Although the mortality is still high, lessons learned from these experiences are now being used in civilian practice and patients with abdominal injuries are being saved that ten or fifteen years ago would have been considered hopeless.

Abdominal injuries may be divided into two classes: Those having external signs of trauma and those not having external signs of trauma. In civilian practice these injuries are about equally divided, whereas in war surgery penetrating and perforating wounds are the predominating type.

### Penetrating and Perforating Wounds

These wounds are the results of bullets, buck shot, stab wounds, bone spicules resulting from fractures, or any sharp object with enough force behind it to make an entrance into the peritoneal cavity. In these injuries the diagnosis is not difficult and an operation is imperative just as soon as justified by the general condition of the patient. If the penetrating wound is caused by a shell fragment or bullet, it is very difficult to determine the organ involved, the extent of damage or final location of the foreign body because of its tendency to ricochet. An x-ray is of great importance in locating the foreign body and from this localization one can decide which approach is best. If there is any doubt as to whether the peritoneum is penetrated, the tract should be excised and this will show whether or not the abdomen should be opened. This is a safer procedure than probing the wound which usually is of little benefit and may be harmful, because of the possibility of pushing infectious material into the peri-

toneal cavity, or of causing a recurrence of an arrested hemorrhage. A point to be remembered is that penetrating wounds of the chest, buttocks, perineum and thighs, may and frequently do enter the abdomen. The so-called thoraco-abdominal, or abdomino-thoracic wound is a common injury encountered in war surgery. In penetrating stab wounds of the abdomen, you have a good general idea of what organs are involved, depending upon the point of entrance. An x-ray here is of little value.

### Perforating Wounds

Perforating wounds are wounds which enter the abdomen and also make an exit. An anterior posterior perforating wound is usually not so serious as one going from side to side. By knowing the wounds of entrance and exit, an excellent idea of the organs involved and where to best make the incision is obtained.

### Non Penetrating Wounds

The diagnosis in these injuries may be very difficult. They are caused by falls from a height, run over accidents, compressions, blows to the abdomen by dull instruments, or anything causing a great increase in intra-abdominal pressure. The solid or fixed organs are more likely to be injured by run over accidents and diffuse blows, while injury to the intestines, mesentery and bladder are more commonly caused by circumscribed or local blows that force the viscus against the spinal column. The most common injury caused by increased intra-abdominal pressure is rupture of the diaphragm. There are, often associated injuries causing more pain and the abdominal injury may be temporarily overlooked, or may be completely missed until it is too late. Thoracic and spinal traumatic conditions often cause symptoms suggesting intra-abdominal injury. Clinically, these patients when first seen may not present a picture of intra-abdominal injury, and when symptoms of injury are present they may be very variable. These patients should be seen frequently and observed for signs of peritoneal irritation and shock. It is often very difficult to differentiate between intra-abdominal injuries and in-

juries to the abdominal wall. Cullen points out that free blood in contact with the peritoneum produces an irritation which often causes severe pain suggestive of an intra-abdominal lesion. Ileus frequently occurs with severe contusion of the abdomen without intra-abdominal injury. X-rays are often of value as free air may be seen in the peritoneal cavity, however, a negative x-ray does not rule out an injury of a hollow viscus. Complete blood count, hematocrit and a urinalysis are always of diagnostic aid. Vomiting, fast pulse, pain, tenderness and shock make a clinical picture that is unmistakable and warrants immediate exploration.

### Important Considerations in Abdominal Injuries

The viscera of the abdominal cavity may be classified as follows: The solid organs such as the liver, spleen and kidneys; the hollow organs such as the stomach, intestines, gallbladder and urinary bladder. The supporting structures such as the mesenteries, peritoneal reflections, blood vessels and nerves. The persistent danger in injury to the solid organs and supporting structures is hemorrhage; whereas, the danger in injury to a hollow viscus is from perforation and infection. A hollow viscus is not as apt to be ruptured when empty as when filled with fluid or air. The larger the amount of spilled intestinal contents, the more severe the chemical reaction and infection. Shock secondary to peritonitis caused by gross fecal contamination of the peritoneum with no major blood loss carries with it a grave prognosis.

In spillage of the contents of a hollow viscus into the abdominal cavity, one should consider the composition of these contents. Secretions from the stomach and small intestines contain chemicals which produce an immediate inflammatory reaction and they also contain bacteria which are responsible for the later true peritonitis. On the other hand, solid material from the colon is heavily contaminated with bacteria, but has little secretion and the inflammatory reaction produced is largely a bacterial peritonitis with a relatively slow onset. Generally speaking, the chemical irritant decreases from above downward, while the pathogenic bacterial content increases. We are familiar with the immediate inflammatory reaction from a ruptured peptic ulcer and can easily understand why the clinical picture of a wound of the stomach differs

from a wound of the sigmoid colon, which is capable of producing a more severe type of peritonitis and, therefore, carries a higher mortality.

Bile and urine also cause a peritonitis which is slow in developing, but can be of a severe nature. Blood alone causes peritoneal irritation, but may be present in rather larger quantities without being suspected.

The morbidity and mortality of these injuries are dependent to a large extent upon the time lag, or number of hours which have elapsed between the injury and operation, also, to the number of organs involved and the damage inflicted to these organs. If the patient is in shock, one should try to determine whether it is caused by hemorrhage, or peritonitis, or both. A patient in severe shock for a number of hours may be resuscitated properly and withstand a long operative procedure, but still die in 48 hours of uremia, the uremia being the result of anuria due to a prolonged ischemia of the kidneys.

### Pre-Operative and Operative Care

The most efficient supportive procedure used in the treatment of the severely injured in World War II was the copious administration of blood. Its pre-operative value in replacing blood loss and its continued use during the long operative procedure of severe abdominal injuries cannot be over emphasized. Severe hemorrhagic shock should be combatted by giving blood rapidly and by several routes if necessary. However, too rapid replacement of massive blood loss may be dangerous, especially to a patient with diminished cardiac reserve. The amount of blood required for replacement after hemorrhage is underestimated many times as indicated by anemia in the immediate post treatment period. Signs that the patient is ready for surgery are a slowing of the pulse, a rising blood pressure, and warming of the extremities. These signs show the patient is on the rise and resuscitation continues during the operation. A continuous fast pulse with a falling blood pressure despite shock therapy suggests active bleeding and demands immediate operation. Also, waiting for a normal pulse and blood pressure and a patient in perfect condition may cause renewed hemorrhage and lead to irreversible shock.

Other important preoperative measures are sedation, nasal oxygen if the patient is in shock, and elevation of the foot of the bed. The stomach should be emptied.



A Levin tube should be inserted into the stomach and left in place during and after the operative procedure.

### Operation

The operative management is about the same whether it is a penetrating or non-penetrating wound. The right or left rectus incision either low, middle or upper with lateral extension if necessary, will usually be adequate for complete visualization of all abdominal organs. In upper left abdominal injuries which involve the fundus of the stomach, spleen, splenic flexure of the colon and diaphragm, the approach of choice in my opinion is the transthoracic. All blood and intestinal contents are quickly aspirated from the peritoneal cavity. A thorough search is made for bleeding points which when found are to be clamped and ligated. A complete exploration of the entire peritoneal cavity is then made.

### Stomach Injuries

The operative management of these injuries may be simple or very difficult, depending upon the location of the injury. Injuries high up near the esophagus are not easily exposed. It must be remembered that any anterior wall perforation may extend through the posterior wall. For this reason, one should not hesitate to divide the gastrocolic omentum and enter the lesser sac to obtain a thorough view of the posterior wall of the stomach. Injuries of the stomach if closed early have a good prognosis.

### Duodenum Injuries

These wounds are not common, but when found should be sutured in layers like any other perforation of the small intestine. The possibility of not finding retroperitoneal perforations when present is a hazard, which must not be overlooked. If there is any doubt as to the presence of such an injury, the duodenum must be mobilized and a thorough search made. Retroperitoneal portions of the duodenum like the colon have no peritoneal covering and when sutured are more likely to break down and leak than are anterior perforations.

### Small Intestines

The small intestines are inspected from the ligament of Treitz to the ileocecal valve. It is preferable to close all per-

forations transversely. Two rows of sutures are used. Frequently there are multiple openings close together with mesenteric damage, and a resection of the damaged part is necessary.

### Colon Injuries

A large portion of the colon is retroperitoneal and perforations can easily be overlooked. For this reason and for the known insecurity of sutures with subsequent danger of leakage, it was an order in the recent war to exteriorize all colon injuries. In certain portions of the colon like the splenic flexure and descending colon this was often rather difficult, but it was an advancement in the treatment of abdominal injuries that had much to do with the mortality. In private practice today with the use of antibiotics, we believe that many lacerations of the colon can be safely repaired, especially those of the right side. Tears with an undetermined amount of damage to the bowel wall should be exteriorized. In injuries to the rectum below the peritoneal reflection, the treatment of choice is drainage through the buttocks, suturing the perforation and the establishment of a proximal colostomy.

### Liver Injuries

Injuries to the liver are two fold. The immediate danger being that of hemorrhage and the secondary danger is that of infection due to a bile peritonitis. For this reason all injuries to the liver should be operated as early as possible and a drain placed down to the margin of the tear. Hemorrhage from the liver is rarely fatal because the blood in the liver is under a relatively low pressure and the bleeding is mostly venous, unless a branch of the hepatic artery is opened. The lacerated liver can be sutured, but this is rarely necessary especially since the advent of hemostatic packs. If severe hemorrhage is encountered, it may be temporarily controlled by digital compression of the hepatic artery and portal vein at the foramen of Winslow.

### Gallbladder Injuries

Gallbladder injuries are not common and if small, can be sutured. If large tears are present, the gallbladder may be removed or a cholecystostomy done. An injury of the hepatic or common bile duct may be closed over a T tube.

### Pancreas Injuries

These injuries are rare, but when present the clinical signs are usually those of excruciating pain in the epigastrium with severe shock. The lacerated area should be sutured and hemorrhage controlled. In repairing an injury to the pancreas, it is important to keep in mind the relationship of the head of the pancreas to the common bile duct and duodenum. In repairing injuries to the body and tail of the pancreas, important structures to be avoided are the splenic vessels and mid-colic artery. The blood serum amylase test is of value, as in other abnormal conditions of the pancreas.

### Diaphragm Injuries

A ruptured diaphragm is the only serious abdominal injury which does not usually require immediate operation. When immediate operation is necessary in these injuries, it is because of respiratory and cardiac embarrassment resulting from hemorrhage and evisceration of the abdominal contents into the pleural cavity, causing marked increase in intra-thoracic pressure. In bullet and stab wounds penetrating the diaphragm there are usually associated intra-abdominal injuries which require immediate operation. It may be months before this condition is suspected. X-rays are of utmost importance in making a diagnosis. In our series of cases, a ruptured diaphragm was frequently seen in injuries to the abdomen. The left side is more often injured than the right.

### Spleen Injuries

The spleen is a very friable organ and when torn or lacerated, there is usually severe hemorrhage because of the high arterial pressure present. If the primary hemorrhage is not severe, the patient may go undiagnosed and a secondary hemorrhage may occur a week or more later which may be fatal. For this reason these injuries are very dangerous and every effort should be made to diagnose them. Often an x-ray is beneficial in showing an elevated left diaphragm. Tenderness in the upper left quadrant with dullness in the left flank and pain in the left shoulder are all signs and symptoms of a splenic injury. The spleen should always be removed, as suturing is unsatisfactory because of the extreme friability of the organ.

### Kidney Injuries

A nephrectomy is indicated for tears of the vessels of the pedicle, or for extensive fragmentation of the kidney. Most kidney lacerations can be controlled by suturing or using hemostatic packs. If there is a tear of the pelvis it should be sutured. Kidney injuries should be drained retroperitoneally through the flank.

### Bladder Injuries

Wounds of the bladder may be intra-peritoneal or extra-peritoneal. Intra-peritoneal bladder injuries lead to peritonitis where extra-peritoneal injuries are followed by an extravasation of the urine causing a destructive cellulitis which may be fatal unless early drainage is established. All bladder perforations should be closed as early as possible and the bladder decompressed by constant drainage through a suprapubic cystostomy. When rupture of the urinary bladder is suspected, catheterization usually obtains no urine or bloody urine. Sterile saline solution injected into the bladder which does not return, or only partially returns, usually confirms a diagnosis of perforation.

### Major Blood Vessel Injuries

In abdominal injuries very few patients live to have larger arteries repaired or ligated. This is not the case in lacerations and tears of large veins. The vena cava can be successfully sutured, or it is safe to ligate the vena cava below the level of the renal veins.

### Post Operative Care

These patients are all treated practically the same post-operatively as they either have a peritonitis or a potential peritonitis. It is important to use continuous Wagensteen suction with a Levin tube. During the period that the continuous suction is used, three to four thousand cc of 5% glucose in ringers and distilled water is given every 24 hours intravenously. The amount of fluid given is determined by a chartered urinary output. Proper fluid and electrolytic balance can be maintained in this manner replacing the chloride ions that are lost by the constant suction. Whole blood is given according to the hematocrit plasma protein readings. In this manner the blood volume and serum protein are kept at a normal level which is of utmost importance in wound healing. Penicillin and aureomy-



TABLE I  
PENETRATING ABDOMINAL INJURIES

Site of Injury	No. of Cases	No. Operated Upon	No. of Post Operative Deaths	Total Deaths
Abdominal Parietes and Mesentery .....	2	2	0	0
Diaphragm with Stomach.....	1	1	0	0
Liver Alone .....	1	1	0	0
Liver with Colon .....	1	1	0	0
Liver with Stomach .....	1	1	0	0
Spleen Alone .....	1	1	0	0
Spleen with Stomach .....	1	1	1	1
Small Intestine .....	2	2	0	0
Colon, Small Intestine with Right and Left Chest .....	1	1	1	1
Colon, Small Intestine and Vena Cava .....	1	1	1	1
Iliac Vein .....	1	1	0	0
TOTAL .....	13	13	3	3

TABLE II  
NON PENETRATING ABDOMINAL INJURIES

Site of Injury	No. of Cases	No. Operated	No. of Post Operative Deaths	Total No. Deaths
Diaphragm .....	5	5	1	1
Liver with Spleen .....	1	1	0	0
Spleen with Delayed Hemorrhage .....	1	1	0	0
Liver .....	1	1	0	0
Bladder .....	2	0	2	2
TOTAL .....	10	8	3	3

Table I and II include cases operated at Riverside Hospital, Paducah, during the last five years..

cin are given as long as there is any evidence of infection present. Sedation in the form of morphine or demerol is given as necessary. Early ambulation in these cases is advisable.

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#### DISCUSSION

Lawrence E. Huri, Lexington: About three or four weeks ago I received a letter from Dr. Robertson inviting me to open the discussion on his paper entitled "Abdominal Trauma." Before I accepted this honor two thoughts immediately came to my mind. First, world affairs being as they were, it seemed that he had selected a most timely and appropriate subject and, secondly, that it might be well for many of us to again revive our interest in this subject.

When an individual sustains severe intra-abdominal trauma, for instance, a severe gunshot wound of the abdomen and death ensues, it is most always due to one of two causes. If the individual dies within a few minutes or a few hours after injury, death is usually due to traumatic and hemorrhagic shock. Should the individual survive for one or two weeks, usually the cause of death this long after injury, is sepsis. Injuries to the colon and extra-peritoneal rectum are very likely to lead to sepsis even though initial surgery was carried out

properly soon after injury. Many anatomical and physiological factors are responsible for difficulties encountered in dealing with severe injuries of the colon and rectum. For instance, we all know that the colon is notorious for leakage about suture lines with its subsequent peritoneal contamination and abscess. It is true that since World War II newer and more effective antibiotics, for those organisms normally present in the colon, have been discovered. But in my opinion it would indeed be unwise to depend upon these at the expense of good initial surgery. However, as adjuncts to surgical management of colon injuries the antibiotics are extremely fine. As to operation, I feel it is best to exteriorize the damaged portion of colon as a loop colostomy, whenever possible, or some form of proximal de-

compression of the colon. This stoma should be of a type which will allow for extra-peritoneal closure at a later date.

Those injuries of the extra-peritoneal rectum necessitate defunctioning of the colon proximal to the injury by means of double-barrel colostomy. The wound tract should be debrided thoroughly and drainage of the posterior and perirectal spaces through an adequate incision in the fascia propria. Unless adequate drainage is carried out, in this manner, many deaths will result from ascending infection into the peritoneal cavity.

Again I consider it an honor to open the discussion of Dr. Robertson's paper and I think he has given us a very concise and logical interpretation of a large and difficult subject.

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**Discussion by Jack G. Webb of "An Approach to the Problem of Gastric Ulcer or Gastric Cancer," by J. E. Hix, M. D., cont. from p. 444.**

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pathologist's museum, along with two-thirds of the stomach.

My feeling on this subject was best expressed by a resident of St. Joseph Hospital in Lexington. In a discussion with a group of them on gastric ulcer I asked each one what he would want done if an x-ray diagnosis of gastric ulcer was made on him. The first said he would seek competent surgical advice as to treatment. The second believed he would like to have a gastric resection done the next day, first on the schedule. The last man said that he would prefer to be taken from x-ray to the operating room. This is an exaggeration of the urgency of the matter, but the idea is sound.

The problem of gastric carcinoma is probably the most depressing of all cancer surgery. I do not believe that any great strides

will be made in the direction of earlier diagnosis of this cancer. I am convinced that our only hope for improving the situation is to depend on total gastrectomy as the operation of choice for all cancers of the stomach, since anything less than this is not a radical cancer operation in the accepted sense.

I was impressed greatly by the discussion of Dr. Lahey's paper on total gastrectomy by Mr. Phillip Allison of Leeds, England, who pointed out the fallacy of accepting total gastrectomy, as now done, as a radical cure for cancer. The lymphatics of the stomach drain down to the pancreatic nodes, as well as to the spleen and omentum, and we must consider resection of the body of the pancreas, as well as the spleen and omentum, to be a part of any total gastrectomy.

In closing I would like to plead again that no gastric ulcer be treated medically but that it be handled as the potentially malignant lesion it is and be submitted to subtotal gastric resection when diagnosed.



## *Special Article*

### THE MARYLAND MEDICAL CARE PROGRAM

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BALTIMORE, MARYLAND

In Maryland the need for comprehensive planning for health and medical care has been recognized as a problem of first magnitude. The initiative in this field was taken in 1939 by the Medical and Chirurgical Faculty of Maryland, which proposed in an open letter that "a new Section or Standing Committee of the State Planning Commission be constituted, whose function it shall be to keep under constant survey the problems of medical care for the citizens of this State and to formulate from time to time recommendations for better utilization and for extension of existing medical facilities, and for the institution of such new facilities as are required." This committee is composed primarily of outstanding physicians but includes representatives of allied professional groups, as well as representatives of the public. It was organized early in 1940 and in spite of interruptions caused by the war has been extremely active. Because of the outstanding leaders who have given so generously of their talents, the committee recommendations have been supported by professional and lay groups and with few exceptions have been incorporated into law.

Maryland is a relatively small state with a population of approximately two million. About half of the population lives in the City of Baltimore, and the other half lives in the twenty-three counties. The counties are predominately rural but include urban areas surrounding Baltimore City and Washington, D. C., and a few fairly large communities, such as Cumberland, Hagerstown, Frederick and Salisbury. The medical care needs of the City of Baltimore are so different from those of the counties that they have been dealt with separately both in the studies which have been made and in the programs which have been developed.

The studies of the Committee on Medical Care have covered a broad field, the most important of which are summarized below:

#### **Medical Care in the Counties of Maryland<sup>1</sup>**

The first project of the committee was to study the needs for medical care in the more rural parts of the State, that is, in the counties. The program which was developed is discussed in the latter part of this paper.

#### **Construction of Chronic Disease Hospitals**

The committee recognized the need for hospital facilities to care for persons suffering from chronic illness. It, therefore, endorsed the recommendations of the Almshouse Commission<sup>2</sup> for the construction of chronic disease hospitals. These recommendations were subsequently translated into legislation authorizing the construction of three chronic disease hospitals with a total of 1,600 beds. One hospital is now in operation and a second is under construction.

#### **Licensing of Hospitals and Nursing Homes**

The committee's recommendation that all hospitals and nursing homes be inspected and licensed by the State Department of Health was enacted into law in 1945.

#### **Medical Care in Baltimore City**

In 1944, a special subcommittee was appointed to develop plans for medical care for low income groups in Baltimore City. A report of this committee was published January 1947<sup>3</sup>, and legislation implementing the proposed program was passed later that year.

#### **Survey of Hospital Facilities**

Another subcommittee of the Committee on Medical Care made a detailed survey of the hospital facilities and needs of the State in accordance with the pro-

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visions of the Federal Hospital Construction Act. In accordance with the recommendations<sup>1</sup> of this committee, the State Department of Health was named to administer the Hospital Construction Program. The committee developed a master plan for hospital construction for the State, based on a careful analysis of needs and developed a priority schedule placing most important construction first.

### **Tuberculosis Hospitals**

The committee recommended that the administration of the four State Tuberculosis Hospitals be transferred to the State Department of Health in order that the activities of these institutions might be more closely integrated with the program for the prevention of tuberculosis. This recommendation was implemented by a law passed in 1947.

### **Mental Hygiene**

In dealing with the problem of mental disease, the committee made several recommendations, all of which have been subsequently adopted by appropriate bodies. They recommended that a hospital for acute psychiatric disorders be constructed as a part of the University of Maryland Hospital. It recommended that budget allocations for the administration of State mental hospitals be substantially increased to make it possible to raise standards of care. It recommended the creation of a Division of Mental Hygiene in the State Department of Health, with the responsibility of developing a non-institutional mental hygiene service utilizing the clinic facilities of the Health Department and integrated with the professional program of the State mental hospitals.

Only the first of the recommendations given above will be discussed here, but the others are mentioned in order to give emphasis to the broad planning program which has been developed and the remarkable success which the Committee on Medical Care of the State Planning Commission has had in gaining acceptance of its proposals. The Medical Care Program for the counties of Maryland is merely one segment of a much larger and broader program designed to improve the health and medical care facilities for the people of Maryland.

### **Medical Care For the Indigent and Medically Indigent of the Counties of Maryland**

The first project of the Committee on Medical Care of the State Planning Commission was to study the needs in the counties of Maryland. A field survey of each county was carried out in order to evaluate the particular needs of individual counties. On completion of the study in 1944<sup>1</sup> the Planning Commission had reached the conclusion that there was no agency in the State, either official or non-official, whose particular responsibility it was to see to it that the poor received adequate medical care. The remedial recommendations of the commission were endorsed by the State Medical Society, and in 1945 a law was passed charging the State Department of Health with the responsibility of administering a program providing medical, hospital, nursing, and dental care for the indigent and medically indigent of the state. The term "indigent" has been defined for the purposes of this program as those persons who are recipients of public assistance from the Department of Public Welfare. A person is "medically indigent" when he is unable through his own resources to provide himself and his dependents with proper medical, dental, nursing, and hospital care without depriving himself or his dependents of necessary food, shelter, clothing, and similar necessities of life. The program has been in operation for four years, and it is now possible to examine some of its strengths and weaknesses.

### **Development of Administrative Policies**

In developing the administration of the program, the Health Department has been conscious of three basic responsibilities which must be carried out simultaneously.

#### **1. Responsibility to the patient.**

The program resulted from public recognition of the fact that there is within the State a group of citizens who cannot provide themselves with adequate medical care through their own resources. The program must provide this care if it is to justify its existence.

#### **2. Responsibility to the public.**

The program is financed through general taxation. The public has a right to expect that services be provided efficiently and at reasonable cost.



3. Responsibility to those who provide services.

Administrative policies must be kept within the area of agreement that is developed with the professional groups who provide services. Success of the program depends to a large degree on the active support and participation of physicians, dentists, nurses, pharmacies, and hospitals.

The law provides for a Council on Medical Care whose function it is to counsel with and advise the Health Department in the development of the program. This council is a cornerstone of the program. It is composed of fourteen men and women, representatives of the organized medical, hospital, pharmaceutical, dental and nursing professions, the State Board of Health, the State Department of Public Welfare, the Commission on Mental Hygiene, the Tuberculosis Sanatoria, and the two medical schools. The Council held its thirty-seventh meeting recently. Through the device of subcommittees, it has subjected every important phase of the program to intensive study and analysis. The Council, as well as the Department of Health, had adopted an experimental approach toward the program. All policies are regarded as tentative and are modified from time to time in the light of experience. Although the Council is purely advisory and has no actual authority, its recommendations have been so well thought through that with rare exceptions they have been accepted without modification by the State Board of Health.

#### Decentralization

Early in the development of the program it was recognized that, to be most effective, the administration of the program should be decentralized and local administrative authority placed in the hands of the County Health Departments. This plan was made possible by the fact that since 1936 there has been a full time Health Department in each county of Maryland. The director of the county Health Department is on a full time basis and serves both as County Health Officer and as Deputy State Health Officer. These Health Officers are all physicians and are intimately acquainted with the health and medical needs of their county. Their close association with physicians, dentists, and pharmacists has been an important factor in smoothing out administrative problems which develop from time to time.

To strengthen the Health Officer in administration of the program, a County Advisory Committee on Medical Care was organized in each county. These committees are composed of representatives of local medical, dental and pharmaceutical societies, representatives of county departments of education, welfare, and health, representatives of the County Commissioners, and outstanding laymen who have demonstrated an interest in the medical care needs of low income groups. These committees meet periodically to review the progress of the program, to consider ways and means of extending and improving the services offered, and to deal with any abuses which are called to their attention. They also hear appeals of recipients of services, or persons rendering services who feel that they have a complaint to make concerning some administrative decision. The principle of local administration has been of great importance in adapting the program to varying local needs and in securing the active participation and support of professional and lay groups in the counties.

#### Eligibility

All persons receiving public assistance are eligible for medical care. About 17,500 such individuals are certified periodically to the Health Department by the Welfare Board. This group is referred to as the "indigent," and they are automatically supplied with identification cards establishing their eligibility for a six month period. If they continue on public assistance, the card is renewed.

Persons who are not on relief but who are unable to pay for needed medical care have the right to make application to the County Health Department. They complete a one page application which includes a brief statement of their financial resources. If the income is within the limitations established by the program, then they, too, are supplied with cards certifying their eligibility for a specific period of time. In determining eligibility, the Health Officer has broad discretionary authority to take the varying social, medical, and economic factors into consideration.

Those who are eligible are instructed, in the event of illness, to go directly to their private physician, who provides those services which are indicated by the medical condition. Similarly, if dental care is needed, the patient goes directly to his private dentist.

### Scope of Services

The principal services provided through the program are home and office visits by physicians, maternity care, consultation with specialists, diagnostic laboratory examinations, drugs prescribed or dispensed by physicians, dental prophylaxis, extraction and filling of teeth, and hospitalization in chronic disease hospitals or general hospitals as needed. Bedside nursing care on a limited scale is provided through the public health nurses working in the counties.

In addition to the above services provided directly by the Medical Care Program, patients are urged to make full use of the preventive services offered through the clinics of the Health Department, such as immunization, prenatal care, well baby care, routine chest x-rays, venereal disease treatment, and examination in cancer detection clinics.

The staffs of the eleven branch laboratories of the State Department of Health have been enlarged in order that they may perform clinical laboratory tests for medical care patients. Most of these laboratories are now able to offer to the physician the usual hematological examinations, blood chemistry, urinalysis, serological tests, and bacteriological examinations.

### The Physician

The State and County Medical Societies have supported the Medical Care Program from the beginning. They are represented on the planning group, the Committee on Medical Care of the State Planning Commission. They are represented on the Council on Medical Care which guides the Board of Health in the development of administrative policies, and they are represented on each County Advisory Committee.

At the end of each month the physician submits a simplified medical report for each patient whom he has treated during the month under the program. This report is reviewed and approved by the County Health Officer and forwarded to the State Office, from which payment is issued. There are approximately 25,000 persons in the counties who are in possession of certificates of eligibility. Of this number approximately 7,000 receive physicians' services each month. Up to the present time over 1,000 physicians have participated in the program. A substantial number of these physicians have their offices in Baltimore City and a few are out of State.

The majority of the physicians, however, have their offices in one of the counties. The number of physicians participating each month is approximately 500. It is seen that the majority of physicians are taking an active part in the program. This is also true of dentists and pharmacists. There is no limitation on the amount of service a physician renders or on drugs he prescribes. Payment is on the fee-for-service principle, following a uniform fee schedule recommended by the Council on Medical Care.

### Costs

The program, exclusive of hospitalization, is operating with an annual appropriation of \$540,000. Since the population of the counties is about one million, this amounts to a per capita expense of 54 cents per year. Monthly expenditures are currently at the rate of \$45,000. During the past year the breakdown of expenditures was as follows: 74 per cent for physician care; 7 per cent for dental services; 18 per cent for drugs; 1 per cent miscellaneous other services.

There are approximately 17,500 recipients of public assistance in the counties, and this constitutes the eligible "indigent" population. Each month about 23 per cent of these receive physician services. The cost of providing care for this group is approximately \$20 per person per year.

Due to the limited appropriation only a small number of medically indigent persons have been certified to the program. This group accounts for about one third of the patients receiving care. The cost per case for this group is substantially higher than for the indigent, primarily because the medically indigent tend to be certified only in the event of serious illness, whereas the indigents are automatically certified whether they are sick or not. They receive care of minor as well as serious illnesses.

### Limitations of The Program

There are a number of factors which place limitations on this program. The law defines the program as being for the indigent and medically indigent. It is, therefore, necessary to apply a means test to determine eligibility. Application of a means test is expensive and technically difficult. No matter how carefully the test is devised and regardless of how skillfully it is applied at the local level, there will always be those who complain



that the test is too liberal and others that it is too strict.

As described previously the services are purchased on the fee-for-service principle. Medical care purchased in this manner tends to be expensive and is subject to abuse unless safeguards are established. The constant review of experience of the program by County Advisory Committees has been very valuable in reducing abuses to a minimum. The fee-for-service system is not conducive to full emphasis on preventive medicine as contrasted to curative medicine. The preventive services must be offered largely through Health Department clinics.

In a program of this type it is rather difficult to have any substantial influence on the quality of service rendered. The program is purchasing for the low income group the same type and quality of care as is generally available to the community. There are large areas in Maryland which lack adequate diagnostic and consultation services. It is not economical, however, to establish new facilities through a program which is serving only 3 per cent of the population.

This program offers many opportunities for experimentation in ways of improving and extending health services. Several small scale projects are under way in particular counties, which may later lead to significant improvements in the program. In one county a demonstration is in progress which within a year or two may answer some of the questions regarding the amount and type of nursing service needed in rural communities. In this county the number of public health nurses has been increased to a ratio of one nurse to each 2,800 population. In addition to the usual public health service, the nurses are offering bedside nursing care on a visit basis for all patients referred by physicians. Under the direction of the private physician the nurse will go into the home as often as needed, give the usual bedside care, administer prescribed medications, and carry out any other nursing orders left by the physician. It is hoped that with this service it will be possible for some patients who formerly would have been hospitalized to receive adequate care in the home. This service may also make it possible for physicians to reduce the number of home calls.

In two counties it was possible to have two-thirds of the patients under the program examined by a dentist and the den-

tal defects charted. On the basis of this survey and others which will be carried out later, the dental phase of the program will be modified so as to meet more nearly the actual dental needs of the patients.

The extension of services offered by branch laboratories to include clinical laboratory procedures will enable physicians to make more accurate diagnosis and thereby improve the quality of the care. Many of these laboratories are in areas of the State where no other clinical laboratory facilities are available. One objective of the program is the establishment of clinics for the periodic examination of well adults. Such clinics would be conducted along the lines of well baby clinics and cancer detection clinics which have already demonstrated their usefulness. The examinations performed in these clinics would be adapted to the conditions most likely to occur in particular age and sex groups. The development of a series of consultation clinics in the major specialties is envisioned for the more rural areas of the State. Some such clinics have previously been established in pediatrics, obstetrics, orthopedics, otology, and cardiology. Most of these were in existence prior to the development of the Medical Care Program. It is proposed that they be extended to cover the other major specialty fields in the counties which need them and in which the physicians express a desire to have them. As pointed out previously, one of the difficulties in establishing clinics of this type is the fact that the Medical Care Program provides service to only a small fraction of the population. If consultation clinics are developed on any wide scale, it will probably be necessary to work out a plan whereby they may be utilized by a larger segment of the population.

One of the most significant achievements of the program has been the development of County Advisory Committees on Medical Care. In several counties these committees have developed into highly significant community groups which concern themselves with all aspects of the health needs of the Community whether related to the Medical Care Program or not. They have served to bring together community agencies which previously had functioned without relationship to each other. The future development and expansion of these committees can prove to be a valuable tool in a continuing analysis of the health and medical care needs of the community, and in de-

veloping new resources designed to meet these needs.

### Summary

Maryland has developed a highly effective instrument for analyzing and developing plans to meet health and medical needs through the standing Committee on Medical Care of the State Planning Commission. One of the recommendations of this committee has resulted in development of a Medical Care Program for low income groups in the counties. Administration of this program has been worked out jointly by the Health Department, which is the administration agency, and the professional groups which are called upon to provide the services. The program assures persons in low income groups of access to a type and quality of medical care which is about on a par with the care which is generally available in the community for patients who can afford to pay. Physicians are assured of reasonable payment for their services to this group, and are thus relieved of a heavy burden of charity practice. Through development of new diagnostic laboratory facilities in branch laboratories of the Health Department, development of consultation clinics, and through extension of bedside nursing care, the program promises to have a favorable influence on the quality of care provided. The program offers numerous other opportunities for experimentation in methods of improving the quality of medical care.

The endorsement of the program by the medical profession represents an important landmark in Maryland. It represents the finding of a common ground of agreement as regards medical care between State government and the medical profes-

sion. The responsibility of government to provide care for the medically indigent is clearly recognized, and a framework is established for developing partnership between government and the profession, with the goal of bringing high quality care to a group of the population who in the past have received grossly inadequate medical care. The importance of this common ground of agreement between government and the medical profession cannot be overemphasized.

The discussion of public medical care has frequently been so inflamed by proposals totally unacceptable to professional groups that many have gained the impression that cooperation toward a common goal is impossible. Professional groups resist sweeping proposals placing government in a dominant position in medicine because they are afraid of what it will do to them as individuals and as professional groups. This seeming impasse can be resolved if agreement can be achieved on limited programs and if state and local governments can administer these limited programs in such a way as to provide improved services through administrative methods acceptable to physicians, dentists, and hospitals. Mutual confidence of professional groups and government can be gained, not by angry debate, but by cooperative exploration of areas of agreement.

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## INDIGENT MEDICAL CARE

Medical care of the indigent is one of the paramount problems that faces the medical profession today. Since the food supply of the indigent is not considered to be a problem of the grocer, the question naturally arises as to why indigent medical care should be considered as a problem of the medical profession. There are good reasons why this is true. First of all, the problem is unquestionably a medical one and it is the responsibility of the medical profession to provide capable leadership in all areas of health and medical care. Secondly, it is most often the have-nots that provide the most fertile breeding ground for all of the various ideologies that threaten Democracy, and jeopardize the practice of medicine as we know it today. Paradoxically enough, even if the profession and the people were saddled with the so-called Utopian scheme of Compulsory Health Insurance, indigent medical care would remain unsolved since,

being unemployed, they would not be eligible for benefits.

Under the private enterprise system, ambition is developed in the individual by rewarding his initiative and industry. The average worker is encouraged to apply himself to his job so that he may enjoy more of the luxuries and comforts of the well-to-do. That this system works is attested by the unparalleled standard of living of the American worker.

Although the system is successful for the majority, there is a minority group that reaps few, if any, of the rewards of private enterprise. They are the ill, the physically handicapped, the misfits, those that are just pure lazy, and those who are willing and able to work but are unable to find employment. Our system of government is, we hope forever, linked with the private enterprise system. If the American people, including the medical profession, are to continue to enjoy free-

In Kentucky the responsibility at present we must make Democracy work by constantly solving its problems. For realistic proof we have only to look at the European nations who failed to do this. It seems logical to us that government should assume the principal burden by providing the necessary funds and that the profession should provide leadership in developing a workable plan.

It is obvious that so long as a person has no money, whatever he has of the necessities of life must come from others. Physicians have traditionally cared for indigents without remuneration and we suspect that a great deal of this will continue regardless of whatever plan may be developed. Many physicians consider it a privilege to render such service, as was expressed by Dr. John Scott of Lexington on the floor of the House of Delegates at the 1950 annual meeting. Nevertheless, the fact remains that this does not wholly answer the problem. Hospital care is not provided for, nor are expensive drugs that can mean the difference between life and death, unless the doctor pays for them out of his own pocket. It is not fair to expect the profession to shoulder the entire burden. It is true that hospitals make their facilities available without charge to a number of indigents, but what is the ultimate result? Operating costs must come from some source if the hospital is to remain solvent and the only source of income to most of them is the patient who is able to pay. It becomes necessary for the paying patient to take care of not only his own bill, but a sufficient additional hidden sum to include operating costs for the charity patient.

It is obvious that this is not a satisfactory answer. The cost should be divided among all of the people by means of the tax dollar. This principle has been concurred in by the American Dental, Hospital, Medical, Nurses, Public Health, and Public Welfare Associations, through their Inter-Association Committee on Health. These Associations further recommend that financing be by means of funds earmarked for the purpose rather than charged against funds available for cash assistance payments to individuals.

In Kentucky the responsibility at present legally rests upon the fiscal courts of the 120 counties. Every practicing physician knows how inadequate and feeble are efforts in this direction in most of the counties. A study made in 1948 by the Health Committee of the Kentucky Welfare Association showed that 25 counties made no provision for indigent medical care; 21 provided restricted and very limited care, while 74 made some attempt at furnishing general medical care for those not able to pay. In 50 counties no hospital care was included; 38 made payments for private hospital care for some indigents; 30 restricted hospital care to specified cases; and there were 2 tax supported hospitals which provided general hospitalization.

State Medical Associations have already taken the lead in a number of other states in setting up plans that are realistically attacking the problem with state governments accepting their responsibility in this area. In Pennsylvania, medical care is provided to indigents as a professional service with payment being made directly to those rendering the service. Physician services, drugs and surgical supplies, nursing and dental services in 1946 cost \$9.39 for an average assistance case, or \$5.62 for each person on public assistance rolls.

Maryland has gone a long way toward meeting the problem without federal aid through the leadership of the Medical and Chirurgical Faculty of Maryland (the state medical society). A description of the Maryland Plan is printed as a Special Article in this issue of the JOURNAL (see page 456). The budget for 1948 was \$543,424. Hospitalization was paid separately and was about equal in cost.

We are not attempting to say what Kentucky's indigent medical care plan should be but we are keenly aware that one is critically needed and that Kentucky physicians should take the lead in establishing it. We believe that individual counties should assume financial responsibility in accordance with their ability to do so, and that the state should provide the remainder of the funds which should be expended under local circumstances.



## DIABETES COMMITTEE PLANS DETECTION DRIVE

The Diabetic Committee of K.S.M.A., in cooperation with the American Diabetes Association, has planned a state-wide Diabetic Detection Drive for the week of November 11-17, 1951.

Dr. Carlisle R. Morse, Louisville, Chairman of the Committee, said, "We want to attempt to make everyone diabetes conscious during the week of the Drive so that we may uncover that million of unknown diabetics that is believed to be among us in the United States and going without treatment or care."

The K.S.M.A. Committee is not attempting to organize the local efforts but has requested each County Medical Society to plan and conduct the Drive through a

committee to be appointed by the President of the Society.

All physicians, laboratories, and hospitals that are equipped to run urine sugar tests are urged to cooperate by providing free examinations to the public. The Ames Company has agreed to supply those cooperating in the Drive with a sufficient quantity of "Clinitest" free of charge.

County Medical Societies are also asked by the Committee to arrange to have speakers available for civic clubs and other organizations as an educational feature of the Drive.

The Committee is to be congratulated for its work in planning this service in the interest of the public health.

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## TOWARD GREATER ACCURACY IN LABORATORY EXAMINATIONS

A forward step that has been taken by the College of American Pathologists is the initiation of a program to supply its 1450 member pathologists with highly accurate standard solutions used in chemical determinations. Obviously the result of such laboratory procedures cannot be more accurate than the standard solutions used. Studies made in the past have shown wide divergence of strength in standard solutions prepared by technicians in various laboratories. Pathologists who direct laboratories may now check solutions prepared by their own technicians against those supplied by the Col-

lege and adjust them to comparable accuracy. Distribution of standardized dextrose and nitrogen solutions, begun in the latter part of August, is but the initial step in the development of the comprehensive program planned by the College, according to its Executive Secretary, Dr. M. G. Westmoreland.

It has often, but truthfully, been said that inaccurate laboratory examinations are worse than no examinations at all and we congratulate the College of American Pathologists for providing a service that has been badly needed for a long time.

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Health is today recognized as more than the absence of disease, and the field of health is not the exclusive concern of any one profession or specialty, whether that be medicine, social work, education, government or diplomacy. Health is an individual and—more importantly in the last half of the twentieth cen-

tury—a social entity. Custom, usage and necessity have resulted in an undue worldwide preoccupation with disease. Personal health, national health and world health in terms of a balanced global ecology are the great challenge of the second millennium of the Christian Era. Edit., New England J. Med., May 17, 1951.

# ORGANIZATION SECTION

## Special Centennial Section Issued By Courier-Journal, Sept. 23

As a part of the Centennial Celebration of the Association, October 2, 3 and 4, the Louisville Courier-Journal issued a special 22-page Centennial supplement on Sunday, September 23.

Richard R. Slucher, M. D., Buechel, Chairman of the Centennial Sub-Committee in charge of special publications, arranged for this special edition.

Abundantly and attractively illustrated, this supplement carried 45 articles. The material covered all the major phases of the growth of medicine during the past 100 years.

Sister professions supported the issue through the purchase of advertising space, and a number of county medical societies bought space—a total of 95 columns of advertising was carried.

Carey Robertson, Sunday editor of the newspaper, had charge of the news, and Arthur Eyl, manager of the advertising department, was in charge of advertising for the section.

"While our special centennial section was written by laymen primarily for laymen to read, officials of the Courier met with our committees and accepted our advice on appropriate material and consulted us frequently during the preparation of this issue.

"We are grateful to Mr. Robertson, Mr. Paul Hughes and all who participated in preparing the copy for the issue for their sympathetic understanding of the medical approach. We also want to thank Mr. Eyl for his cooperation in the matter of handling the advertising in general and our ad in particular," Dr. Slucher said.

## Dr. Hancock Heads Group to Stimulate Gifts to Medical Education

J. Duffy Hancock, M. D., Louisville, was appointed in August chairman of the committee to raise funds in Kentucky for the American Medical Association Education Fund by C. C. Howard, D. D., Glasgow, chairman of the Council.

Other members of the committee, which was authorized by the Council at the suggestion of the A.M.A., will be named by Dr. Hancock, who will announce his appointees at an early date.

Dr. Hancock said that voluntary efforts to raise funds to aid the 79 medical schools in the United States had already borne fruit. A total of \$1,132,500 already has been granted—physicians contributing 56% of this total.

The Foundation has a minimum annual goal for physicians of \$1,000,000. Donors' names by states and individuals will be published at periodic intervals in the Journal of the A.M.A. Names only and not amounts will be listed.

## Committee Thanks the 64 Technical Exhibitors For Patronage

Appreciation for the support of the Centennial by 64 technical exhibitors, the largest ever to attend our Annual Meeting, exceeding the all time high of the 1950 meeting by nine, was voiced by the Committee on Technical Exhibits.

"We want to express our sincere gratitude to each one of our exhibitors for their patronage and for their contribution in practical assistance to our members at the Centennial," Carlisle R. Petty, M. D., Chairman of the Committee, said.

The 64 Centennial exhibitors were:

Abbott Laboratories  
A. S. Aloe Company  
American Physical Therapy Association, Ky. Chapter  
Ames Company, Inc.  
Ayerst, McKenna & Harrison, Ltd.  
Bilhuber-Knoll Corp.  
Blue Cross - Blue Shield  
Borden Company  
Brown & Williamson Tobacco Corp.  
Burroughs Wellcome & Co.  
Camel Cigarettes  
Campbell Associates  
Central Dairy Council  
Central Pharmacal Company  
Ciba Pharmaceutical Products, Inc.  
Coca-Cola Co.  
Crocker-Fels Co.  
T. M. Crutcher Dental Depot, Inc.  
Dick X-Ray Co.  
Doak's Surgical Supplies, Inc.  
Doho Chemical Corp.  
H. G. Fischer & Co.  
C. B. Fleet Company, Inc.  
General Electric Company  
John Hancock Mutual Life Insurance Co.  
Hoffmann-LaRoche, Inc.  
Holland-Rantos Company, Inc.



Kay Surgical, Inc.  
 Lanier Company  
 Lanteen Medical Laboratories Division, American Cyanamid Co.  
 Eli Lilly and Co.  
 Louisville Surgical Supply, Inc.  
 M & R Dietetic Laboratories, Inc.  
 J. A. Majors Company  
 S. E. Massengill Company  
 McNeil Laboratories, Inc.  
 Mead Johnson and Co.  
 Medical Protective Company  
 William S. Merrell Company  
 C. V. Mosby Company  
 National Drug Company  
 Ortho Pharmaceutical Corp.  
 Parke, Davis and Company  
 Prescription Opticians of Kentucky, Inc.  
 A. H. Robins Company, Inc.  
 Sandoz Chemical Works, Inc.  
 Schering Corp.  
 Sealy Mattress Company  
 G. D. Searle & Co.  
 Sharp and Dohme, Inc.  
 Smith-Dorsey Company  
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 Templar-Thelan X-Ray Co.  
 U. S. Vitamin Corp.  
 The Upjohn Company  
 Vanpelt and Brown, Inc.  
 Winthrop-Stearns, Inc.  
 The Max Woche & Son Co.  
 Wyeth, Inc.

### **Council Adopts 12 Point Statement As Association's Objectives**

A statement of "The Twelve Objectives of the Kentucky State Medical Association" was unanimously adopted by the Council at its August meeting.

The Council, at its December 29, 1950 meeting, instructed the Public Relations Committee to draw up a statement of policy, and authorized the committee to call on such members for assistance as it deemed necessary.

Committee Chairman, Sam A. Overstreet, M. D., Louisville, asked all elected officers of the Association to participate in framing the statement. Following study of the material Dr. Overstreet sent out, the group was convened into an afternoon and evening session.

The twelve objectives are:

#### **ETHICS**

1. To constantly improve the high standard of ethics of our profession and inspire by example and precept among medical students and young practitioners a sanctity of the trusts committed to us.

#### **CITIZENSHIP**

2. To encourage the members of our profession to participate in local activities of civic improvement and building of good American citizenship.

#### **LEADERSHIP**

3. To assume an alert leadership in all matters pertaining to health to the end that we may provide for all Kentuckians the best medical care which the State's resources will afford.

#### **COOPERATION**

4. To secure the cooperation of all professions and agencies in a constructive and progressive program of health throughout the state.

#### **PREPAID CARE**

5. To promote prepaid hospital and sickness insurance to individuals as well as groups through our own and reputable private agencies.

#### **THE PUBLIC**

6. To inform the public of the problems of medical service and how they may secure the best medical care, and to solicit their confidence and cooperation in efforts devoted to their best interest.

#### **INDIGENTS**

7. To provide more equitable and adequate medical care for indigent citizens in every community.

#### **PUBLIC HEALTH**

8. To actively cooperate with the State Department of Health and with local health departments in initiating and carrying out a sound public health program designed to control preventable disease and to safeguard the health of the people.

#### **INSTITUTIONS**

9. To constantly promote the improvement of curative medical care in our State Tuberculosis and Mental Hospitals and to coordinate and support programs that combat heart disease, cancer, diabetes, poliomyelitis, and other similar devastating diseases.

#### **HOSPITALS**

10. To expand and improve present hospital facilities to the end that all citizens may have available within their reach the benefits of the best scientific diagnosis and treatment of disease.

#### **EDUCATION**

11. To educate an adequate number of physicians, nurses, and technicians and seek their more equitable distribution to all communities; to foster medical research and extend to all the benefits of postgraduate study.

## LEGISLATION

12. To maintain close liaison with the Federal, State and County governments to the end that the best health interests of our citizens will be served.

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**Diabetic Committee Announces Plans  
For Detection Week, Nov. 11-17**

The Diabetic Committee of the Association will sponsor a state wide Diabetic Detection Drive during National Diabetic Detection Week, November 11-17, 1951, Carlisle Morse, M. D., Louisville, Chairman, has announced.

The purpose of the drive is to make everyone in the community "diabetes-conscious," to have everyone in the community screened "free of charge" during Diabetic Detection Week, and to send those whose tests prove positive to their family physicians. The Committee's program, the first of its kind for the state as a whole, was endorsed by the Council at its August 30 meeting

President Sam A. Overstreet, M. D., has contacted all county medical societies, asking each to appoint a County Diabetic Committee. When the county committee is appointed, it will be urged to promote its own drive, using the medical facilities available to the county and community. Assistance of the county health department, the schools and civic organizations will be solicited.

Materials to be used in making the tests will be supplied by the American Diabetic Association through the Headquarters Office of this association. Promotional materials will also be available to the counties. Dr. Morse urges those counties which have not sent in the names of their county committees to do so at their first convenience.

"This Diabetic Drive is not to raise money, but to promote a greater health service to the people of Kentucky, to discover unknown diabetics and to bring known diabetics a better knowledge of their disease and improved methods of managing it so that they may live happy, useful lives," Dr. Morse said.

The other members of the State Diabetic Committee are George Burger, M. D., Covington; William P. Hall, M. D., Paducah; Frank Moore, M. D., Bowling Green; and Martin Palmer, M. D., Hazard.

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**Association to Offer Telephone  
Postgraduate Course**

Live, fresh scientific programs, presenting the latest in medical sciences by top-flight talent and broadcast by telephone, will be offered to the local county medical societies of this

state by the Kentucky State Medical Association, in cooperation with the University of Louisville School of Medicine.

This program of telephone postgraduate education has been authorized by the Council and will be under the supervision of the Association's Committee on Medical Education. It is scheduled to be staged for one hour each month during February, March and April.

The programs will emanate from the Medical School and will be under the direction of and arranged for by Herbert L. Clay, M. D., Louisville, director of postgraduate refresher training. These broadcasts, which are a part of the Council's program of bringing the latest in medical knowledge to the local level, will be transmitted to the central office in Louisville and "piped" out to the subscribing county societies. The only expense to the county society other than a very small charge for the course, is the arranging for amplification in its regular meeting hall.

The Indiana State Medical Association is now in its second year of successful telephone medical broadcasts. Programs for members of the dental profession have been broadcast successfully by phone on a national basis for several years.

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**Dr. Bailey to Head Committee to  
Promote W.M.A. Membership**

Clark Bailey, M. D., Harlan, was appointed chairman of a committee to promote membership in the World Medical Association by C. C. Howard, M. D., Chairman, following authorization of the committee by the Council at its August 30 meeting.

Dr. Bailey, a charter member of the World Medical Association, was given authority to name the other members of his committee. There are now approximately 45 K.S.M.A. members in the W.M.A.

Elmer L. Henderson, M. D., Louisville, served as president of the World group for the 1950-51 year.

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**AMA Clinical Session Dec. 4-7**

Postgraduate study primarily designed for the general practitioner will be the theme of the 1951 Clinical Session of the A.M.A., to be held in Los Angeles, December 4-7, states George F. Lull, M. D., Chicago, secretary and general manager of the A.M.A.

Hotel reservations can be made in advance by writing to Chairman, A. M. A. Subcommittee on Hotels, 1151 South Broadway, Los Angeles 15, California.



### Dr. Gaither Host at Hopkinsville

Physicians, hospital administrators and guests from 25 Western Kentucky counties attended a meeting on civil defense and hospital facilities at the Hopkinsville Country Club, August 28, as guests of J. Gant Gaither, M. D., Hopkinsville.

The program was presented by John W. Cronin, M. D., Bureau of Medical Services of the Federal Security Agency, Washington; Francis Weber, M. D., U. S. Public Health Service, Cleveland; Bruce Underwood, M. D., Louisville; and Haynes Barr, M. D., Owensboro.

The meeting, called by the Christian County Medical Society, was presided over by Delmas Clary, M. D., Hopkinsville, president.

### Fifteenth District Meets in Bell

Despite heavy rains thirty-five physicians and their wives attended the annual meeting of the Fifteenth Councilor District at Clear Creek Springs, September 13, Charles D. Ca-wood, M. D., Middlesboro, has reported.

Robert C. Long, M. D., Louisville; Allen L. Cornish, M. D., Lexington; and W. Vinson Pierce, M. D., Covington, presented scientific papers. Bell County was host to the visiting physicians.

### Southern Association Meets in Dallas

The 45th annual meeting of the Southern Medical Association will be held in Dallas, Texas, November 5, 6, 7 and 8, Curtice Rosser, M. D., Dallas, President of the S. M. A., has announced.

A program of 47 sessions is being prepared, most of the activities to be presented in the Adolphus and Baker Hotels in downtown Dallas. Those wishing to make hotel reservations should write to Housing Bureau, Southern Medical Association Meeting, 433 Medical Arts Building, Dallas 1, Texas.

### U. of L. Gives Wed. Evening Course

A ten lecture basic course in Electrocardiography, which began September 12th, is being given by the University of Louisville School of Medicine, in conjunction with the Kentucky State Medical Association, on Wednesday evenings from 7:00-9:00 at Louisville General Hospital. Remaining lecture dates are October 10, 17, 24 and 31, November 7, 14 and 21.

All inquiries concerning the course should be addressed to Herbert L. Clay, Jr., M. D., Director, Post Graduate Refresher Training, University of Louisville School of Medicine.

### Army Delays Aug.-Sept. Draft of MD's

The planned induction of 333 Priority I physicians originally scheduled for August, and once delayed temporarily, has again been delayed at the request of the Department of Defense, and the scheduled induction of 152 Priority I physicians for September also has been temporarily postponed.

The Department of Defense emphasized that the request was based entirely on a sustained volunteer rate of doctors applying for Reserve Commissions in the Armed Forces, and does not represent a reduction in requirement for medical officers.

### Clock Dedicated to Irvin Abell

A clock honoring Irvin Abell, M. D., bought from contributions to the School of Medicine, made in place of flowers sent to his funeral, was dedicated September 13 at the University of Louisville School of Medicine, where he taught 50 years.

Dr. Abell's grandson, Irvin Abell, III, unveiled the memorial plaque at the base of the clock tower at First and Chestnut. J. Murray Kinsman, M. D., Dean of the School of Medicine, introduced Oscar O. Miller, M. D., a University of Louisville trustee, who made a short dedicatory address. Dr. Abell's death occurred in August, 1949.

### Centennial Volume to Be Published At Early Date

If you did not reserve your copies of the Centennial Volume while attending the 100th Birthday Celebration of the Association in Louisville, October 2, 3 and 4, or if you were not fortunate enough to attend, please contact either the secretary of your county medical society or the Headquarters office.

The Centennial Sub-Committee on the historical publication suggests that you make your reservations for this beautiful volume, in the manner indicated above, at a very early date, in order that the Committee may know how many volumes to order.

This beautifully bound memento will contain all the scientific essays presented at the Centennial session, together with pictures and biographical sketches of the essayists. In addition, it will include pictures of all the K.S.M.A. Presidents and Secretaries. There will be a historical sketch of the Association and an article on Ephraim McDowell. Other features will be found in this publication, which will be edited by Emmet Field Horine, M. D.

### Kentucky Physician Averaged \$10,744 1949 Income Survey Reports

The average net income of all physicians in Kentucky (independent and salaried) in 1949 was \$10,744, according to physician income data compiled for each state by the Department of Commerce and the A.M.A. in their survey of physicians' incomes, 1929-49.

Independent physicians practicing in Kentucky made an average net income of \$11,782 in 1949, and salaried Kentucky physicians averaged \$6,354.

An average net income of \$15,291 was earned by independent physicians practicing in Louisville, income data, covering the year 1949 for the 32 largest cities in the U. S., disclosed. Salaried physicians in Louisville averaged \$7,344.

The average income for all physicians in the city was \$13,335.

The survey revealed that the highest average incomes earned by independent practitioners were found not in the largest cities, but in places of about 350,000 population. Regionally, physicians' incomes were highest in the Far West and lowest in New England.

The average net income for all physicians in the U. S. was \$11,058, before taxes, in 1949. Among independent physicians, general practitioners reported an average net income of \$8,835; full specialists reported \$15,014. Neurological surgeons, with an average net income of \$28,628, had the highest incomes among full specialists in 1949. Pathologists, with \$22,284, and gynecologists, with \$19,283, followed.

Frank G. Dickinson, director, and Charles E. Bradley, of the Bureau of Medical Economic Research of A.M.A., and William Weinfield, business economist for the Department of Commerce, conducted the survey.

### U. of L. Staff Members Given Grants

Three members of the faculty of the University of Louisville School of Medicine have been awarded research grants by the Public Health Service of the Federal Security Agency, a release from Washington stated.

Sheppard M. Walker, M. D., and Charles A. Woerner, M. D., received grants for heart disease research, made by the Heart Institute of the National Institutes of Health and approved by Leonard A. Scheele, M. D., Surgeon General of PHS.

Dr. Walker, associate professor of physiology, was given \$5,635 for research in "chemical changes affecting the mechanical and electrical

response of muscle." Dr. Woerner, associate professor of anatomy, received \$9,400 for research in "the relation of fat metabolism to hardening of arteries."

A grant of \$6,000 was made to William A. Brodsky, M. D., assistant professor of pediatrics, for study in "renal and neural factors concerned with the water and electrolyte economy of the body."

### Annual Cancer Symposium to Be Held in Louisville, Nov. 8

The Fifth Annual Cancer Symposium, sponsored by the Kentucky Division, American Cancer Society, in cooperation with the Kentucky State Medical Association, will be held in the Ballroom, Henry Clay Hotel, Louisville, Thursday, November 6, 1951.

The following program will be presented:

8:00-9:00 A.M. Registration

9:00 A.M. Gastrointestinal Cancer  
(Sound technicolor film)

9:30 A.M. Hormones in Relation to Cancer  
Ira T. Nathanson, M. D.  
Boston, Massachusetts

10:15 A.M. Cancer of Oral Cavity  
Joseph L. Bernier, D. D. S.  
Alexandria, Virginia

11:00 A.M. Treatment of Urogenital Tract Cancer  
Reed M. Nesbit, M. D.  
Ann Arbor, Michigan

12:00 Adjournment for Lunch

1:15 P.M. Relationship of Rectal Polyps and Rectal Carcinoma  
Garnet W. Ault, M. D.  
Washington, D. C.

2:00 P.M. Malignant Lesions of Lower Oesophagus and Greater Curvature of Stomach  
Herbert Acuff, M. D.  
Knoxville, Tennessee

2:45 P.M. Cancer of the Breast  
C. D. Haagensen, M. D.  
New York, New York

3:30 P.M. Cancer of the Cervix  
Gary H. Twombly, M. D.  
New York, New York

4:15 P.M. Adjournment

Members of the Kentucky Academy of General Practice will be given credit for attending the Cancer Symposium.

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COLLEGE OF PHYSICIANS  
OF PHILADELPHIA



## *Pertinent Paragraphs*

The annual meeting of the Indiana State Medical Association will be held in Indianapolis on October 29, 30 and 31.

The Fifth Congress of the Pan-Pacific Surgical Association will be held in Honolulu, November 7-19, 1951, F. J. Pinkerton, M. D., President, has announced. In addition to attending an outstanding surgical conference, doctors may enjoy a vacation in Hawaii and are urged to bring their families with them. All hotel and travel reservations should be made through the Association office, Suite 7, Young Hotel Building, Honolulu, Hawaii.

The Occupational Outlook Handbook, prepared by Labor Department and Veterans Administration, reports "excellent opportunities" in medicine and that "demand for medical care will probably continue to rise in the future." Among factors tending to increase the demand for physicians are the increase in population; government provision of medical care for veterans and members of the Armed Forces; and the planned large-scale hospital construction program in areas which have no modern facilities.

Veterans Administration announces the appointment of Paul L. Eisele, M. D., a native of New Albany, Indiana, as manager of the V-A Hospital in Waukesha, Wisconsin. Doctor Eisele was formerly chief of professional services at the V-A Hospital in Springfield, Missouri.

Starting in January the Army will re-examine all draftees who have failed pre-induction mental examinations. The overall Army rejection rate for the last year averages 35.1 per cent, in contrast with the World War II rate of 22.7 per cent, and 15.2 per cent of all examined were rejected on mental tests alone.

The Defense Department has protested a military appropriations bill rider which would require the release by November 30 of all inactive or volunteer reserves who served a year or more in World War II and have been on active duty now for 12 months, claiming it would mean release of thousands of reserves in key spots. The Army is checking its records to determine how many medical officers would be affected.

A 140% increase in Social Security payments for the first year of the expanded program is reported by Federal Security Agency. Payments, which averaged about \$62,000,000 a year ago, are now \$147,000,000; automatic increases have boosted average individual old-age retirement payments from \$26 to \$48; and the maximum has gone from about \$45 to \$68.

The Wisconsin State Medical Society has announced that a scholarship fund is being raised by contributions from physicians and the public to help needy students get through medical school and locate in Wisconsin. The Kentucky State Medical Association has had a similar fund since 1946 when the Rural Kentucky Medical Scholarship Fund was established by donations from physicians and the public to assist students who are interested in practicing in rural areas.

Alex J. Steigman, M. D., Professor of Child Health at the University of Louisville School of Medicine, has received a \$23,635 Grant-in-Aid from the National Foundation for Infantile Paralysis, Inc., for studies on experimental poliomyelitis.

Arthur P. Tiernan, Executive Secretary, Vanderburgh County Medical Society, Indiana, reports that their annual Doctors, Dentists and Druggists picnic had a record turnout and was a big success. Each group takes its turn at being host to this gathering which has been an annual affair for the past 14 years.

"Supplies of whole blood today are woefully inadequate and the essential reserve is not being created," the Defense Department disclosed as the nation-wide blood donor campaign began, September 10. The campaign aims at procuring 2,800,000 pints of blood by July, 1952, but to reach this total, the number of donors must be increased more than sevenfold. Approximately 300,000 pints will be needed each month to attain the goal; in the most recent month for which figures are available, only 40,000 were donated.

The American Goiter Association offers the Van Meter Prize Award of \$300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The essays may cover either clinical or research investigations; should not exceed 3,000 words; and a typed, double spaced copy in duplicate should be sent to

Corresponding Secretary, George C. Shivers, M. D., 100 East Saint Vrain St., Colorado Springs, Colorado, not later than March 1, 1952.

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**Kentucky reported 97 cases of malaria in July**, according to Leonard A. Scheele, M. D., Surgeon General of Public Health Service, who believes danger of recurrence of malaria epidemics of 25 and 50 years ago "is with us today" because of growing incidence of malaria among military personnel returning from Korea. Kentucky was one of seven states reporting over 600 new cases during July, the majority contracted outside the U. S.

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**Defense Production Administration has allowed another 7,500 tons of steel** (a 10% increase over original allocation) and 450,000 pounds of copper (20% increase) for hospitals and other health claimants during the last four months of this year.

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**Death rates in the U. S. for several important diseases—including acute poliomyelitis, tuberculosis and measles—fell significantly in 1950 compared with 1949**, according to Federal Security Administrator Oscar R. Ewing in a statement based on vital statistics compiled by the Public Health Service. The death rate for acute poliomyelitis, per 100,000 population, fell off by 39% in 1950; the tuberculosis death rate dropped 16%; and the death rate for measles was cut in half.

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**Veterans Administration has announced it will establish two distribution centers**, in Washington, D. C. and Denver, Colorado, to supply eligible veterans with hearing aid batteries and stump socks for artificial limbs directly, cutting the time required for delivery from weeks to a few days.

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**The Army Medical Department is functioning at a high rate of efficiency and contributing to troop morale**, Surgeon General George Armstrong, back from Korean inspection trip, says. He reports that 75% of Korean wounded men return to duty, that only 14% of these men had to be sent back to this country for hospitalization, and that the death rate of wounded has been reduced to 2.5%, in contrast to 4.5% in World War II.

**Duke University School of Medicine and Duke Hospital, Durham, North Carolina**, announce a series of lectures, for October 13, October 27, and November 10, 1951, sponsored by the North Carolina Academy of General Practice. Tickets for the football games that will be played on each of the days of the lectures may be obtained by writing to Mr. H. M. Lewis, Department of Athletics, Duke University. The lectures are planned to take the place of the Annual Symposium that Duke University School of Medicine has been offering for many years.

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**The American Urological Association offers an annual award of \$1000.00** (first prize of \$500.00, second prize \$300.00 and third prize \$200.00) for essays on the result of clinical or laboratory research in Urology. For particulars write Dr. Charles H. Shivers, Secretary Boardwalk National Arcade Bldg., Atlantic City, New Jersey. Essays must be in before February 15, 1952.

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**The U. S. Atomic Energy Commission has accepted 2 proposals for private firms to study the commercial feasibility of manufacturing, processing and selling radioisotopes**, a release from Washington states. Contracts have been signed with Bendix Aviation Corp. of Detroit, Michigan, and Tracerlab, Inc., of Boston, Massachusetts.

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**An Epidemic Intelligence Service has been formed by Public Health Service**. The new outfit, starting out with 21 specially trained PHS medical officers, will assist in investigating disease outbreaks "beyond resources of state and local health departments to control." It may also play an important role in event of biological warfare. A. D. Langmuir, M. D., chief of Epidemiological Services of the Communicable Disease Center in Atlanta, has been placed in charge.

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**A proposal for allowing deduction of most medical expenses, including health insurance premiums, from taxable income has lost out in the Senate**. The Senate Finance Committee rejected it, saying that the proposal would mean a tax loss of \$700 million a year and, when the argument was carried to the floor, the Senate would not reverse the recommendation of its Finance Committee. However, the Senate did agree to a Committee proposal for allowing persons over 65 to deduct most of their medical costs from taxable income.



## *President's Page*

For me to adequately express my appreciation for the confidence placed in me by my fellow practitioners would be impossible. It was an unexpected and unearned honor. If my efforts during the past two years have in part justified your action taken at Owensboro, I shall be most happy.

I would like for every member of the Association to have the privilege of being President. He would encounter more work than he anticipated but his rewards would be abundant. He would have a clearer appreciation of our problems and objectives and he would develop a very strong sense of fellowship and brotherhood for his colleagues throughout the state.

My gratitude toward those who have helped me cannot be told. The industry, constant vigilance and attention to detail, and the patience toward the President in his inexperience, which those in the central office constantly exhibit, is a real revelation. I have not asked a single member of the Association to serve on a committee or in any other capacity without receiving his cheerful acceptance and cooperation. Let my last word in this office be an expression of my sincere appreciation to each of you individually and a pledge to you of my continued loyalty and labor.

*Sam a. Overstreet*

PRESIDENT

# County Society Reports

## JEFFERSON

The 451st meeting of the Jefferson County Medical Society was held June 18, 1951, at the Seelbach Hotel, with 49 members present for dinner and about 12 additional for the meeting.

The meeting was called to order at 8 p.m. by the President, Dr. L. Lytle Atherton.

The minutes of the previous meeting were read by the Secretary, and approved.

The Secretary read nine communications, two of which required action by the Society, as follows:

(1) Letter from Mr. Harold Brigham asking physicians of the Society to volunteer their services to examine children for Valley Camp, a Red Feather Service.

Motion was made by Dr. R. O. Joplin that recommendation be made to the committee that these children be referred to their family physicians for examinations. Motion seconded and carried.

(2) Letter from Kentucky State Medical Association that the Council of K.S.M.A. had voted to recommend to the House of Delegates at the Annual Meeting in October that the State dues be increased from \$15.00 to \$25.00 a year.

Motion made by Dr. David Cox that our delegates be instructed to support the increase in K.S.M.A. dues from \$15.00 to \$25.00, was seconded and carried.

A brief report of the Library Committee was made by Dr. Oscar Bloch, Jr., regarding recommendations of Dr. Bernard Schneider as to assessments for upkeep of the library. Further discussions will be held at future meetings of the Library Committee.

Dr. Byron Bizot read reports of the Necrology Committee on the deaths of six members of the Society during the past several months, as follows: Dr. James H. Pritchett, Dr. Gordon Buttorff, Dr. Harry M. Weeter, Dr. Paul H. Schwankhaus, Dr. C. C. English and Dr. H. C. Richmond.

Motion carried that these Resolutions be spread upon the minutes and a copy sent to each of the families.

Dr. Louis Foltz, for the Public Relations Committee, gave details of the dinner meeting for doctors' secretaries to be held June 20 at

the Pendennis Club. There was discussion by Drs. Atherton, O. O. Miller, W. C. Gettelfinger.

The following new members were elected:

Mervin B. O'Neil, M. D.

Andrew L. Hoekstra, M. D.

Thomas G. Stigall, M. D.

Richard C. Spear, M. D.

Leonard Singerman, M. D.

John Edward Ryan, M. D.

I. Wilson Gittleman, M. D.

Charles J. Bisig, M. D.

Abraham Sydney Rosenstein, M. D.

The application of Dr. A. M. Barnett for Emeritus Membership was approved.

Dr. Charles M. Edelen asked the Society's approval or disapproval of a social hour preceding the Centennial Meeting of the Kentucky State Medical Association in Louisville this fall. There was discussion by Dr. Joplin, Dr. David Cox, and others, and motion made by Dr. Joplin that the Jefferson County Medical Society have a social hour at the Centennial Meeting of the K.S.M.A. and that money for the party be raised in any way acceptable to the committee.

Dr. Mapother offered an amendment that the money for this social hour be raised by voluntary contribution and the President of the Society appoint a committee to handle it. The amendment was seconded and carried.

The original motion was seconded and carried.

SCIENTIFIC PROGRAM: 8:50 p.m.

Symposium on Cough. Dr. John S. Harter, Dr. Oscar O. Miller and Dr. Woodford B. Troutman.

Following the scientific program, Dr. Joplin reopened for discussion the Society's action earlier in the evening regarding the motion to support an increase in state dues from \$15 to \$25. Because of the small number of members present, he made motion that the subject be referred to the Executive Committee for consideration, to report at September meeting. Seconded. There was discussion by Dr. Alfred Miller, Dr. Richard R. Slucher, Dr. Louis Foltz, Dr. Atherton, and because the consensus of opinion seemed to be that the motion was out of order, Dr. Joplin withdrew the motion and stated he would bring it up at the September meeting.

Adjourned: 9:45 p.m.

Austin Bloch, M. D., Secretary



**McCRACKEN**

The September meeting of the McCracken County Medical Society was called to order by W. P. Hall, M. D., at 6:30 P.M. There were 23 members, 7 guests and four applicants for membership present.

After dinner, Coles Raymond, M. D., of Paducah gave the scientific program. His paper, "The Early Detection of Gynecologic Cancer," was discussed by E. W. Jackson, M. D.

The business meeting was called to order and the minutes were read. The application of H. S. Gardner, M. D., was presented to the society by the board of censors and the motion was made by Walker Turner, M. D., that Dr. Gardner be accepted into the society. Motion seconded by James Ward, M. D., and passed unanimously.

The transfer applications of Guy Cunningham, M. D., from the Jefferson County Society and of C. M. Blanton, M. D., from the Harlan County Society were read with respective county society letters. Dr. Ward made the motion that the applicants be accepted, seconded by E. Pace, M. D., and passed unanimously.

The application of O. D. Maxey, M. D., was read and referred to the board of censors.

The committee for diabetic detection was appointed; Pittman Orr, M. D., chairman, with D. Y. Keith, M. D., and Charles Billington, M. D.

The proposed changes in the constitution by-laws of the Kentucky State Medical Society were discussed and the following motions were made:

The delegates from McCracken County be instructed that the McCracken Medical Society is on record as in favor of increasing the State dues to \$25.

The delegates from McCracken County be instructed that the McCracken County Medical Society is on record as in favor of admitting the colored physicians into the component societies of the State Medical Society.

The first motion was made by Dr. Ward and seconded by Dr. Jackson; the second was made by Eugene Blake, M. D., and seconded by C. J. Purdy, M. D. Both motions were passed unanimously.

The meeting was adjourned at 9:00 P.M.

George H. Widener, M. D., Secretary

**SCOTT**

The Scott County Medical Society held its regular monthly meeting on Thursday, September 6, 1951, at the John Graves Ford Memorial Hospital in Georgetown. The following members were present: Drs. W. S. Allphin, L. F. Heath, P. H. Crutchfield, A. F. Smith, H. G. Wells, D. E. Clark, E. C. Barlow, F. W. Wilt and H. V. Johnson.

Minutes of the previous meeting were read and approved.

Dr. Wilt brought up the question of Dentists giving penicillin and other drugs by hypo and the Secretary read a letter from the Executive Secretary of the State Medical Society covering that point. The letter stated that it was a debatable subject and one to be decided later on.

Dr. Clark then introduced Dr. Jack G. Webb of Lexington, Kentucky, who presented an instructive paper on the surgical aspect of portal hypertension. Emphasis was placed on etiological diagnosis. The surgical technique for each type was then demonstrated and lantern slides shown.

There being no further business the meeting adjourned.

H. V. Johnson, M. D., Secretary

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**WARREN-EDMONSON**

The Warren-Edmonson County Medical Society met September 11, 1951, at the Helm Hotel, Bowling Green, for its regular monthly dinner meeting.

Arthur D. Donnelly, Jr., M. D., delegate to the State Meeting, was instructed to favor dues increase.

A Procurement Committee of Eldon W. Stone, M. D., Robert C. Moss, M. D., and Samuel E. Paris, M. D., was selected to aid the State Committee.

A committee consisting of Frank H. Moore, M. D., Richard O. Green, M. D., and Dr. Donnelly was appointed to cooperate with the State Committee in organizing a Diabetic Detection Campaign.

Robert Long, M. D., of Louisville, presented a discussion of "Uterine Bleeding in Late Pregnancy."

Frank H. Moore, M. D., Secretary

## News Items

**Paul D. Moore, M. D.**, Sacramento, McLean County, announces his association with Philip J. Malagrino, M. D., New York. Dr. Malagrino is a graduate of Bellevue Hospital Medical College in 1924 and interned at Bellevue Hospital, New York. Since then he has practiced in Brooklyn.

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**J. E. Hagan, M. D.**, Hazard, has announced that Marvin W. Blankenship, M. D., is now associated in practice with him. A native of Arkansas, Dr. Blankenship is a graduate of the University of Tennessee College of Medicine in 1951.

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**Gerald Besson, M. D.**, has located in Lynch, Harlan County. Born in New York, he is a graduate of Boston University School of Medicine in 1950 and interned at Mount Sinai Hospital, New York.

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**Frank A. Bechtel, M. D.**, who has just completed his internship at Hurley Hospital, Flint, Michigan, has opened an office in Central City. A Minnesota native, he is a graduate of the University of Louisville School of Medicine in 1950.

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**Kermit E. Jones, M. D.**, has opened an office in Tilford, Perry County. Born in Tennessee, he is a graduate of the University of Tennessee College of Medicine in 1950.

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**Russell L. Moseley, M. D.**, a graduate of Johns Hopkins University School of Medicine in 1950, has located in Lynch, Harlan County. He interned at Baltimore City Hospital, Baltimore, Maryland, and is a native of Indiana.

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**Paul A. Bryan, M. D.**, announces the opening of an office in Ashland. A native Kentuckian, he graduated from the University of Louisville School of Medicine in 1950 and interned at Good Samaritan Hospital, Lexington.

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**Chester M. Blanton, M. D.**, has located in Paducah, where he will specialize in dermatology. A native of Kentucky and a University of Louisville School of Medicine graduate in 1933, he interned at Louisville City Hospital and has been at General Hospital since 1949.

**L. E. Jordan, Jr., M. D.**, and Darrel L. Vaughn, M. D., have announced that George A. Buckmaster, M. D., is now associated in practice with them. Dr. Buckmaster, a native of Indiana, is a graduate of the University of Virginia Department of Medicine in 1950, and interned at Madigan Army Hospital, Ft. Lewis, Washington.

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**William P. Johnson, M. D.**, has announced the opening of his office in Brandenburg. A graduate of the University of Louisville Medical Department in 1916, he formerly practiced in Louisville. He comes to Brandenburg from Houston, Texas.

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**E. Murrel Froedge, M. D.**, a 1949 graduate of the University of Louisville School of Medicine, has located in Glasgow. A native of Kentucky, he interned at Percy Jones Hospital, Battle Creek, Michigan, and at Brooke General Hospital, San Antonio, Texas. He was recently discharged from the Army.

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**James M. Wygal, M. D.**, has been appointed associate professor in psychiatry at the University of Louisville School of Medicine. A graduate of the University in 1945, he interned at the U. S. Marine Hospital, Norfolk, Virginia. He practiced in London, Kentucky, in 1947.

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**Morgan E. Scott, M. D.**, has started a practice in Lynch, Harlan County. A graduate of the Louisiana State University School of Medicine in 1946, he interned at Jefferson-Hillman Hospital and Baptist Hospital, Birmingham, Alabama, and served in the Navy for several years.

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**I. Wilson Gittleman, M. D.**, has opened an office in the Francis Building, Louisville. He will limit his practice to cardiology, peripheral vascular disease and internal medicine. He received his M. D. from the University of Louisville School of Medicine in 1945, and has an M. S. in medicine from the University of Southern California in 1950. He took his internship at Mt. Sinai Hospital, Cleveland, Ohio, and did postgraduate work at Los Angeles County General Hospital, New York Post-Graduate Hospital and Nichols Veterans Administration Hospital, Louisville.



**Charles Lee Preston, M. D.**, who recently completed his internship at Walter Reed Hospital, Washington, D. C., has opened his offices in the Paintsville Clinic. Dr. Preston received his M. D. degree from the University of Cincinnati College of Medicine in 1950.

**Alfred Ellison, M. D.**, Austin, Texas, has joined the staff of the Fuller-Morgan Hospital, Mayfield, where he will specialize in pediatrics. A graduate of the University of Texas School of Medicine in 1944, he did postgraduate work and had a residency at St. Louis Children's Hospital. He has practiced in Petersburg, Alaska, and Sonora, Texas.

**The Muldraugh Hill Medical Society** elected Charles F. Long, M. D., Elizabethtown, as its president for the ensuing year at a meeting held in Fort Knox, August 9.

**Owen L. Davis, M. D.**, Hopkins County, has recently opened an office in Scottsville for the practice of general medicine and surgery. He was graduated from the University of Louisville School of Medicine in 1950, and interned at the Good Samaritan Hospital, Lexington.

**Mary C. Long, M. D.**, a graduate of the University of Louisville School of Medicine in 1943, announces the opening of her office at 5401 Southern Parkway, Louisville.

**William C. Robertson, M. D.**, a native of Missouri, is locating in Leitchfield. A graduate of the Indiana University School of Medicine in 1945, he interned at Indianapolis General Hospital and served in the Army from 1946-48. He has practiced at Ft. Wayne and Shippshana, Indiana.

**Richard H. White, M. D.**, has begun his practice in Hickman. Born in Hickman, he is a graduate of Temple University School of Medicine, Philadelphia, in 1949 and interned and served a residency at Temple University Hospital.

**John E. Cotthoff, M. D.**, announces the opening of an office in Princeton. A native of Omaha, Nebraska, and a graduate of the University of Tennessee College of Medicine in 1948, he interned at John Gaston Hospital, Memphis, Tennessee. He was recently discharged from the Navy.

**Oren A. Beatty, M. D.**, medical director at Richland County T-B Hospital, Mansfield, Ohio, since 1942, has been appointed medical director of Hazelwood Sanatorium, Louisville. Dr. Beatty, a native of Kentucky, was graduated from the University of Louisville in 1930.

**Kearney Adams, M. D.**, Liberty, has announced his association with Cathryn C. Vaden, M. D., Memphis, Tennessee. A graduate of University of Tennessee College of Medicine, class of 1950, Dr. Vaden has recently completed an internship at Jefferson-Hillman Hospital, Birmingham.

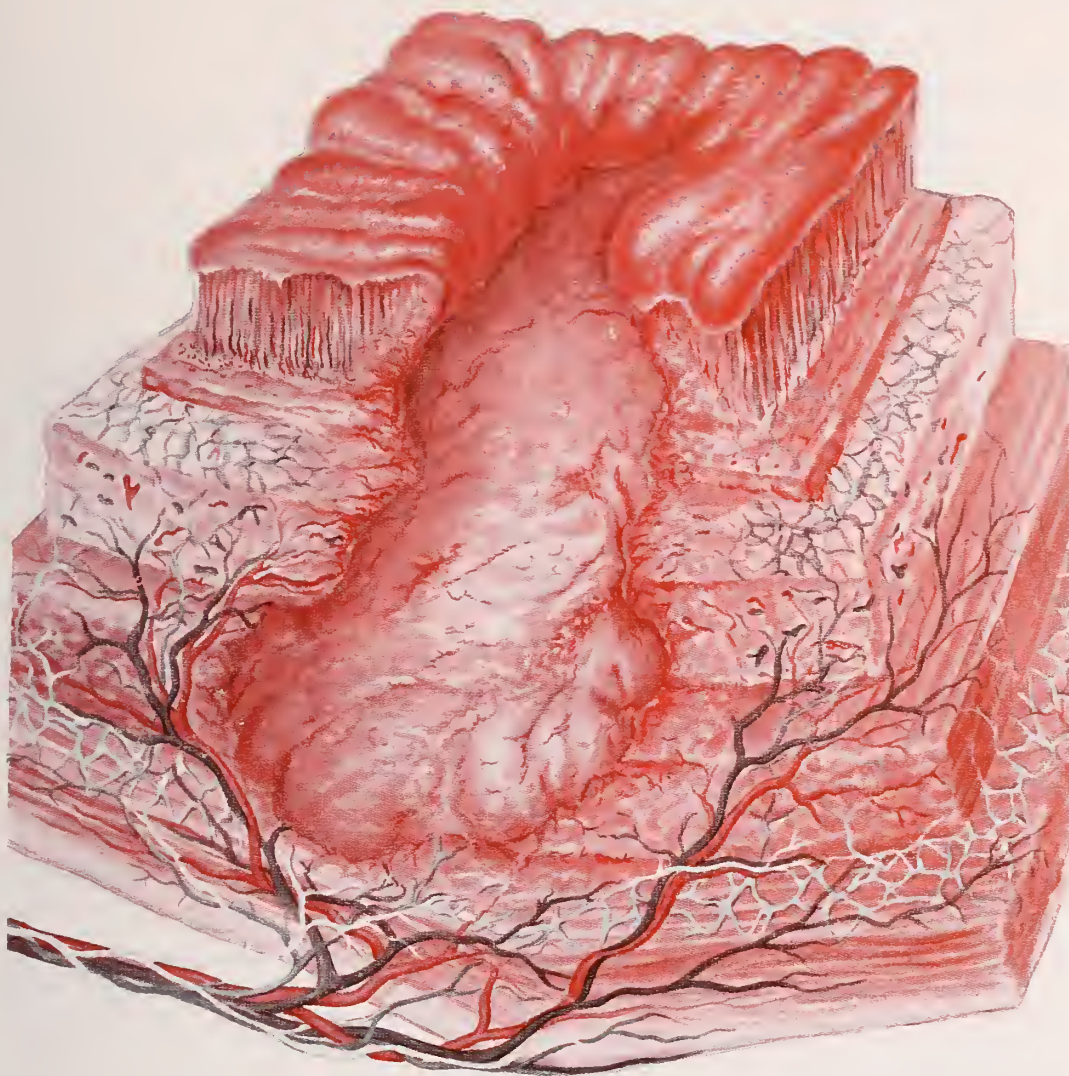
**L. P. Moore, Jr., M. D.**, Greenville, has recently opened an office in Owensboro in practice limited to ophthalmology. Receiving his M. D. degree from the University of Louisville in 1940, Dr. Moore served in the Navy, and then spent three years at the New Orleans Eye, Ear, Nose and Throat Hospital. He was instructor in ophthalmology at Tulane University, and practiced in Little Rock, Arkansas, in 1950.

**John Howard Monroe, M. D.**, a native of North Carolina, has joined the staff of the Fuller-Morgan Hospital, Mayfield, and will specialize in obstetrics and gynecology. Dr. Monroe is a graduate of Harvard Medical School in 1941, and interned at Cincinnati General Hospital. He served 2 years in the Navy.

**Lloyd A. Owens, M. D.**, is now located in Vicco, Perry County. A native of Oklahoma, Dr. Owens is a graduate of Albany Medical College, New York, in 1950. He interned at Good Samaritan Hospital, Phoenix, Arizona.

**F. Buerk Zimmerman, M. D.**, has moved from Louisville to Maysville, where he will practice his specialty, Eye, Ear, Nose and Throat. He is a native of Kentucky, and a graduate of University of Louisville School of Medicine in 1933.

**J. S. Bumgardner, M. D.**, Heyburn Building, Louisville, announces his association with Arthur H. Keeney, M. D., who will limit his practice to Eye, Ear, Nose and Throat. A graduate of University of Louisville School of Medicine in 1944, Dr. Keeney has served residencies at Graduate School of Medicine, University of Pennsylvania, and Wills Eye Hospital, Philadelphia. He is a diplomate of the American Board of ophthalmology.



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## *In Memoriam*

**H. L. WALLACE, M. D.**

**Cadiz**

**1885 - 1951**

Dr. H. L. Wallace, Cadiz, died at his home July 13, 1951 following an illness due to leukemia.

Dr. Wallace was born in Trigg County July 1, 1885 and was graduated from the University Medical Department in 1911 and finished medical school at the unusually young age of 24. He had practiced medicine in Trigg County for forty-one years.

**W. A. KRIEGER, M. D.**

**Newport**

**1887 - 1951**

Dr. W. A. Krieger, Newport, died July 28th at the Veterans Administration Hospital where he had been a patient for six weeks.

A native of Newport, Dr. Krieger attended Newport Public Schools and was graduated from the University of Louisville Medical Department in 1909 and later attended Johns Hopkins University.

He served on the staff of Speers Hospital, Dayton for thirty-five years and during World War II he served on the examining board of Selective Service. He was also health officer and city physician of Newport.

A veteran of World War I, he was a captain in the Medical Corps and served with the 155th Ambulance Corps in France.

## BOOK REVIEWS

**THE PUBLIC HEALTH NURSE AND HER PATIENT:** by Ruth Gilbert, R. N., Coordinator, Course for Mental Hygiene Consultants and Assistant Professor of Nursing Education Teachers College, Columbia University. Published for the Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1951. Price \$3.75.

This second edition has been revised and expanded to include the more recent developments in the field of mental hygiene as related to public health nursing. The author who has had training and experience in both

public health nursing and psychiatric social work, considers ways in which the public health nurse can work with individuals and groups more effectively and with greater satisfaction. This book deals with the art of nursing, the human equation, the complex relationship between the public health nurse and her patient. The author's discussion is penetrating, illuminating and readable. This book should be of value to public health nurses, to social workers, and to nurses in general.

**TECHNICAL METHODS FOR THE TECHNICIAN:** by Anson L. Brown, B. A., M. D., President of Anson L. Brown, Incorporated, successor to: Dr. Brown's Clinical Laboratory and Dr. Brown's School for Technicians, Columbus, Ohio. Published by the Author. Fourth Edition. Price \$10.00.

It is a pleasure to review a book for technicians in which is stressed the methods and procedures rather than theories and where special emphasis is on technique. Without correct technique evaluation is meaningless, and interpretation without value. The new and original illustrations and color plates are noteworthy because they render whatever may be difficult in the text understandable. Lists of questions and terms placed at intervals aid the student in widening his vocabulary and in fixing facts in his memory. For the trained worker the author has included detailed references not given in previous editions.

**THE CHANGING YEARS—WHAT TO DO ABOUT THE MENOPAUSE:** By Madeline Gray. Published by Doubleday & Company, Inc., Garden City, New York, 1951. Price \$2.75.

This book offers infinite help and comfort to women faced with the problems of the menopause. The author is not a physician but conceived the idea of writing this book out of a personal need when following a surgically induced change felt the need of adequate information to answer her many questions and to ease her worries. Being a writer she conducted an extensive research of reading, interviews, and correspondence with many prominent gynecologists and other physicians and gradually accumulated a fund of knowledge which not only answered her own queries, but also covered the many problems which other women might meet. As a result, she undertook to share her knowledge with the reading public.

Singled out for special attack are the erroneous theories that menopause will bring on cancer, insanity, or a decrease in sexuality.

This book is one that the doctor can recommend to his patients facing the menopause

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naturally or by a surgical introduced change as it goes into details the many domestic problems that women encounter at that period of life.

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**ADVANCES IN PEDIATRICS:** Editorial Board: S. Z. Levine, Cornell University Medical College, New York; Allan M. Butler, Harvard Medical School, Boston; L. Emmett Holt, Jr., New York University, College of Medicine, New York; A. Ashley Weech, University of Cincinnati, College of Medicine, Cincinnati. Published by The Year Book Publishers, Inc. Volume IV. 1949. Price \$6.50.

This volume will be welcomed by the general practitioner as well as the Pediatrician because frequently the former is the first one to come into contact with these little patients.

This volume is especially interesting because it presents seven personalized monographs by authoritative contributors. The topics, chosen for their contemporary interest to pediatricists and practitioners alike, fall into two groups; recent advances in methods of diagnosis (three contributions) and recent advances in prophylaxis and therapy (four contributions). The end of the war has permitted the desired participation by foreign authors to this volume and this book now takes on an international flavor.

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**LET'S HAVE HEALTHY CHILDREN:** by Adelle Davis, A. B., M. S., Consulting Nutritionist. Published by Harcourt, Brace and Company, New York 17, New York. 1951. Price \$3.00.

Every expectant mother, be it her first or her fifth child, will want to read this book. She will find advice on how to prevent and overcome "morning sickness," leg cramps, and fatigue, what to do about weight control, and many other complications of pregnancy.

Equally useful information will be found in the chapters devoted to raising a healthy baby. With new emphasis by doctors on the advantages of breast feeding, the methods outlined will be extremely helpful to mothers who wish to nurse their babies. Other advice on feeding infants which includes formula making made easy, prevention of spitting up, skin rashes, eating problems, and similar difficulties faced by the new mother will save her much time and nervous strain.

Mothers can achieve health for themselves, actually feel better during and after pregnancy, and they are insured health and beauty

for their children by following the simple diet rules outlined in this book.

The author explains in an interesting narrative the reasons behind today's vitamin and health food consciousness. Easy to follow charts, menus, and formula recipes make it possible for any woman to become her own expert dietitian from this book.

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**ANATOMY IN SURGERY,** by Philip Thorek, M.D. F.A.C.S., F.I.C.S. Assistant Clinical Professor of Surgery (Formerly Assigned to Gross and Topographic Anatomy), University of Illinois College of Medicine; Diplomate of the American Board of Surgery; Associate Professor of Topographic Anatomy and Clinical Surgery; Cook County Graduate School of Medicine; Member of the American Association of Anatomists; Fellow, American College of Chest Physicians; co-Surgeon in Chief of the American Hospital; Associate Attending Surgeon of the Cook County Hospital; Senior Attending Surgeon of the Alexian Brothers' Hospital, 720 Illustrations, 211 in color. Published by J. B. Lippincott Company, Philadelphia, Pa., 1951. Price \$22.50.

In this book of surgical anatomy, the author has deviated considerably from the usual plan and has presented the material with a stronger surgical viewpoint. Obviously, it will appeal primarily to surgeons and particularly to those in training because operative technic is included with the Anatomy. The entire book is covered in the anatomic discussion and the principles of technic described for the important operations. This method of presentation of anatomic data has an obvious advantage in that it correlates the anatomy with the technical phase of surgery; without question, the young surgeon will find that this integration will make it much easier for him to remember the important anatomic details. The author is to be complimented in the efficiency of the correlation on anatomy and surgery.

Another attractive feature in this volume is the caliber of illustrations, all of which have been furnished by one artist. The drawings are excellent and are to be commended for their clarity and accuracy. It is a relief to note the large size of lettering for the labels; this feature makes it easy to find and identify the various details of a drawing. About half of the illustrations are in color, a feature which adds greatly to their value.

The author is to be congratulated on having prepared a volume with so many fine qualities.

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A REVIEW OF TWO THOUSAND VAGINAL  
DELIVERIES UNDER LOW SPINAL  
ANESTHESIA

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LOS ANGELES

The purpose of this paper is to present a review of two thousand obstetric vaginal deliveries under 10% Procaine low spinal anesthesia. The deliveries occurred during the period of March 1, 1948 to June 1, 1949 and were carried out at the Queen of Angels Hospital, Los Angeles, California. Low spinal anesthetics for obstetric vaginal deliveries were first used in this hospital in July of 1946. Since January 1, 1947 the number has gradually increased and at present 42.9% of all vaginal deliveries are performed using the low spinal type of anesthetic.

TABLE I

PERCENT OF CASES DELIVERED UNDER  
LOW SPINAL ANESTHESIA FROM MARCH  
1, 1947 to JUNE 1, 1948

March 1947	31.3%
April 1947	35.4%
May 1947	34.9%
June 1947	32.8%
July 1947	34.3%
Aug. 1947	30.6%
Sept. 1947	37 %
Oct. 1947	34.1%
Nov. 1947	42.3%
Dec. 1947	30.9%
	34.5%—1947 Average
Jan. 1948	43.9%
Feb. 1948	42.9%
March 1948	41.3%
April 1948	40.9%
May 1948	42.4%
	42.9%—1948 Average

Selection of Cases

Over the fourteen month period covered by this series there were 5369 vaginal deliveries. The series includes both private and clinic patients with approximately 90% of the latter being delivered under low spinal anesthesia. Approximately 70% of these anesthetics were administered by the resident staff, the remaining 30% by the attending staff.

Cases included in the series were unselected as regard to age, parity or duration of gestation. The method has been found to be of special value in cardiac patients and those suffering from upper respiratory infections. Many men preferred to perform breech deliveries under general anesthesia, feeling that the added uterine relaxation afforded by such anesthesia is a needed asset. Of a total of 250 breech presentations recorded in the total series, 48 or 15.2% were successfully delivered under low spinal anesthesia. Sixty percent of these breech presentations were extracted.

(1) Many authorities list multiple pregnancies as a contraindication for this type of anesthetic, but the experience in this series does not substantiate such a belief. Of 48 cases of twins, 17 or 35.4% were delivered under this procedure. The only set of triplets encountered in the total series was delivered without any difficulty under low spinal anesthesia.

There were 1085 primagravidas and 915 multigravidas. The following unusual cases were encountered in the series.



### Unusual Cases Encountered

Premature Labor .....	88
Breech presentations .....	48
Twin Pregnancies .....	17
Mid forceps .....	15
Active Tuberculosis .....	3
Partial Abruptio Placenta.....	3
Duhrssen's Incisions .....	3
Cardiac decompensation .....	3
Acute Pneumonia .....	2
Eclampsia .....	2
Pre-eclampsia .....	2
High forceps .....	1
Bandl's ring .....	1
Prolapsed cord with hand presentation .....	1
Polyhydramnios .....	1
Face presentation .....	1
Brow presentation .....	1
Placenta Previa Marginalis....	1
Cyclops .....	1
Hypertension .....	1
Epileptic .....	1
Triples .....	1
Syphilitic .....	1

### Technique

Most patients received analgesia that consisted of combined demerol and scopolamine in standard doses. Barbituates are rarely used for analgesia in our department. A very small percentage of multigravidas received no analgesia due to the rapidity of their labor. In cases not receiving analgesia, the effectiveness of the low spinal anesthetic was definitely altered. Not only is the administration more difficult, but the ultimate efficiency of the anesthesia decreased. Without analgesia, the patient is more susceptible to sympathetic stimulation.

The following routine is closely adhered to at this hospital. The anesthetic is given to primagravidas when the dilation is complete and the station at least plus two. With multigravidas, the anesthetic is administered when the dilation is 8 c.m., the station a plus two and pains vigorous and regular. The progress of labor has not been altered in any cases in which these criteria were closely adhered to. The blood pressure and fetal heart tones are regularly checked during the period of labor. The patient is placed on her side with the knees approximating the chest, producing a slight convexity of the back. The lower three fourths of the patient's back is surgically prepared. The third and preferably the fourth interspace is chosen as the site of injection. No local anes-

thesia is used for the skin. Local infiltrative anesthesia of the skin was used on some cases, but was abandoned because it was not deemed a necessary adjunct. A number 22 gauge spinal needle is next introduced into the subarachnoid space and 40 to 60 mgms. of 10% Procaine solution is diluted, to one c.c. with aspirated spinal fluid. The injection is made between pains to prevent an unwanted ascendency of the anesthetic agent.

Following injection of the anesthetic agent, the patient is placed on her back and the table tilted to a 15° Fowler's position for five to ten minutes. A pillow is placed under the patient's head and she is made ready for the delivery. If the patient is kept in this 15 degree Fowler's position for longer periods than ten minutes, the chances of obtaining a saddle type of anesthesia are enhanced.

A moist cotton eyepiece is placed over the patient's eyes and she is encouraged to go to sleep. The shielding of the patient's eyes from the lights and disturbing sights of the delivery room cannot be over-emphasized. Patients who have not had the protection of this shield are restless and manifest signs of sympathetic stimulation, detracting from the efficacy of the anesthetic.

Complete pain insensibility is produced within five minutes. The anesthetic reaches a level just below the umbilicus and lasts from sixty to 100 minutes, depending on the dose of anesthetic administered. When this series was first initiated, the usual dose was 70 mgms., but observation and study has caused a reduction to the present average of fifty mgms., with some multigravidas being given 40 mgms. The average dose of fifty mgms. permits the obstetrician a good ninety minutes to complete the delivery and repair.

### Control of Blood Pressure

Vasopressor medication is used only if the systolic and diastolic readings fall to near shock level, which have been exceedingly rare in the cases presented. An oxygen mask is placed over the patient's face and she is given continuous oxygen throughout the delivery. This administration of continuous oxygen stabilizes the blood pressure and insures oxygenation of the unborn infant. In a fair percentage of the cases a slight rise over the basal blood pressure has been observed. A trained nurse-anesthetist sits with all pa-

tients and checks the blood-pressure at ten minute intervals. She also administers continuous oxygen and keeps the obstetrician informed as to the condition of the patient. All delivery rooms are equipped with routine vasopressor agents, intravenous fluids and plasma, any of which may be used without the slightest delay.

TABLE II

SUBDIVISION OF TOTAL NUMBER OF VAGINAL DELIVERIES DURING PERIOD COVERED IN REPORT

Total — 5369	
Spontaneous .....	2377 44.2%
Low forceps .....	2657 49.4%
Mid forceps .....	29 0.6
High forceps .....	2
Breech Assist and Extract .....	250 4.8
Twins .....	48 0.9
Triplets .....	1
Version and Extract.....	5

TABLE III

TYPE OF DELIVERY UNDER LOW SPINAL ANESTHESIA

Total — 2000	
Spontaneous .....	529 26.4%
Low forceps .....	1389 69.5%
Mid forceps .....	15 .8
High forceps .....	1
Breech Assist and Extract .....	48 2.4
Twins .....	17 .9
Triplets .....	1

TABLE IV

COMPARISON OF VAGINAL DELIVERIES UNDER GENERAL ANESTHETIC AND LOW SPINAL ANESTHETIC

	General	%	Low Spinal	%
Spontaneous	1829	54.8	529	26.4
Low Forceps	704	37.6	1389	69.5
Mid Forceps	34	.1	15	.8
High Forceps	2		1	
Breech	250	5.1	48	2.4
Twins	48	1.5	17	.9
Triplets	0		1	
Version & Extract	5		0	

### Anesthetic Failures

There were twenty-six, or 1.3% failures. In this group are included cases where a successful tap was obtained, but resulting anesthesia unsatisfactory, also several

cases where the Procaine solution was not injected because of a bloody tap. We have been very hesitant to inject the anesthetic solution unless a return of clear spinal fluid is effected. It is of note that several of the cases in this group did not receive any analgesia and although a successful tap was obtained, the resulting anesthesia and restlessness of the patient was of sufficient import to necessitate the administration of supplemental gas anesthesia.

### Third Stage

It is shown that the incidence of retained placenta is higher under low spinal anesthesia. Of a total of 40 cases of retained placenta encountered in the total series 32 or 80% resulted in those cases delivered under low spinal. If a placenta is not delivered within thirty minutes it is considered retained and manually removed. Oxytoxics are routinely administered, either during the birth of the shoulders, or at the completion of the second stage. This incidence of retained placenta may have been due to the anesthesia or the administration of the oxytoxic with the birth of the shoulders since it is generally agreed one is more likely to encounter a retention of the placenta when an oxytoxic is administered so early in the third stage of labor.

### Blood Loss

Blood loss has been difficult to estimate accurately. However, the extra-uterine blood loss resulting from the episiotomy wound is probably more profuse under the low spinal anesthesia.

Of the postpartum hemorrhages, 22 or 40% of the cases were in those receiving spinal anesthesia.

TABLE V

### RETAINED PLACENTA

All Cases	40
Low Spinal	32 80%

TABLE VI

### POST PARTUM HEMORRHAGE

All Cases	55
Low Spinal	22 40%

### Side Effects

The only serious side effect encountered in the series resulted from the injection of a vasopressor substance into the spinal fluid mixture with the anesthetic agent. The patient experienced several



convulsions and went into profound shock. She received anti-shock therapy and was discharged from the hospital without any untoward results. After that experience, the administration of intrathecal vasopressor substances was discontinued.

(2) Headache was the major difficulty encountered. The headache problem following low spinal anesthetics has been reported by various authorities as the chief unsatisfactory side effect. Our overall incidence of 9% confirms these reports. However the majority of these headaches were temporary in nature and only a very small percentage of patients were discharged from the hospital with persistent headaches.

The majority of patients were instructed to lie flat for a period of eight hours following delivery, the possibility of a headache being given to the patient as a reason for this order. Of interest, one small group was treated in direct divergence to this, being placed in a modified Fowler's position on return to their bed and absolutely no mention of the word "headache" being made. In this group, the incidence of headache has been much smaller.

Patients who give a history of migraine should not receive low spinal anesthetics because of the very high incidence of post delivery headaches developed in this group.

#### Contraindications for Low Spinal Anesthetics

There is no uniformity of opinion regarding contraindications for this procedure. Our experience has shown that this is a relatively simple procedure, but should be performed only by those who have had sufficient training in the technique. The possibility of overdosage is mentioned but should never occur under capable administration. Most of our men agree that the procedure is contra-indicated in any disease of the central nervous system. Many consider cases of hypertension of hazardous risk. Certainly, marked spinal deformities must be excluded from the list as should any patient giving a history of migraine. Women of emotional instability patterns might be best excluded from this type of anesthesia because of the possibility of psychic trauma. Opinions are divided as to efficacy of this type of anesthetic in multiple pregnancies and breech

presentations. In this series, no difficulty was encountered in either of these situations.

#### Results

There were no maternal deaths in the series and only one maternal death in the total number of deliveries for this period—this was an eclamptic who expired following a cesarian section. Since practically all of these cases were placed on a regime of early ambulation, the incidence of catheterizations was minimal and certainly no higher than encountered in all vaginal deliveries, regardless of the type of anesthetic used. The marked advantage of this anesthetic procedure in cardiacs and those suffering from upper respiratory infections is conclusive. The elimination of nausea and vomiting and the subsequent danger of aspiration of gastric contents has made for a more rapid post partum recovery.

#### Results With Prematures

There was a total of 390 premature infants delivered, 101 of which expired in the premature nursery after a variable number of days. The smallest of the premature infants delivered weighed one pound and thirteen ounces, was delivered under general anesthesia and survived. Eighty-eight or 22.5% of the total were delivered under low spinal anesthesia.

The overall mortality rate for the period of study was 25.1%. Those delivered under general anesthesia had a mortality rate of 26.1% while those delivered under low spinal anesthesia had a mortality rate of 25%.

There were nine sets of twins delivered under low spinal anesthesia, with only two infants out of eighteen expiring. The one set of triplets encountered in the total series was delivered under low spinal anesthesia and all survived.

TABLE VII

#### RESULTS WITH PREMATURES

(A) Total Number of Prematures	
Delivered .....	390
Mortality .....	101—25.1%
(B) Total Number Delivered Under	
General .....	302
Mortality .....	79—26.1%
(C) Total Number Delivered Under	
Low Spinal .....	88
Mortality ... ..	22—25%

### Summary and Conclusions

1. Two thousand cases of vaginal delivery using 10% Procaine anesthesia have been reviewed.
2. The cases were unselected.
3. The technique is described. It is relatively easy to perform and has minimal side reactions.
4. There were 1.3% failures.
5. The incidence of operative deliveries is definitely increased.
6. The incidence of retained placenta is apparently increased.
7. The incidence of postpartum hemorrhage does not seem to be increased from our figures.
8. There were no maternal deaths.
9. The postpartum period was greatly enhanced and the general well being of

the patient much better than under other forms of anesthesia.

10. Spinal headaches was the principal deleterious feature of the procedure and this only made up 9% of all cases.

11. It is felt from the figures presented that this is a procedure of high merit in the vaginal delivery of obstetrical patients. Its advantage in cardiac, upper respiratory infections is proven.

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## PULMONARY RESECTION FOR CARCINOMA AND INFLAMMATORY DISEASE OF THE LUNG

Richard R. Crutcher, M. D.

LEXINGTON

The purpose of this paper is to present briefly some of the steps leading up to the present concept of diagnosis and treatment of carcinoma of the lung, lung abscess and bronchiectasis. Case reports of 16 patients treated by pulmonary resection are presented.

### Carcinoma of the Lung

The first successful total pneumonectomy for carcinoma of the lung was performed by Dr. Evarts Graham in 1933. The patient, a physician, is living and practicing medicine today. This tumor was an early epidermoid carcinoma. The fact that this patient is well 17 years later is probably more significant than most of the statistics of survival rates in lung cancer. The resections for carcinoma of the lung have been largely resections of advanced carcinoma. Ochsner<sup>1</sup> reports that of every three patients in whom the diagnosis of carcinoma of the lung could be established on reasonable clinical grounds, one was eliminated as a candidate for operation because the growth was obviously inoperable, one had a non-resectable tumor proved at operation (or

refused operation), and one had an actually resectable tumor. In other words, only one case in three is resectable and a much smaller group could be classed as early.

Overholt<sup>2</sup>, in studying 721 patients with carcinoma of the lung, estimates the average patient waits three months after the onset of symptoms before seeking advice. He states that by the orthodox methods physicians use to sort out patients with cancer of the lung from those with other conditions, there is another seven months delay. In view of this discouraging number of advanced cases and the small number of early carcinoma of the lung which are now being seen, Overholt<sup>2</sup>, Churchill<sup>3</sup>, and others advocate the use of mass X-ray surveys in the cancer age group of adults. This has been used effectively in tuberculosis and is beginning to be used in a few places for lung cancer. Surveys have been made in Minneapolis, Seattle, New York State, and Washington, D. C. The yield is estimated to be about ten primary cancers of the lung for every 100,000 persons examined. In addition, there are discovered many benign tumors, cysts, inflammatory lesions and other conditions requiring treatment.

Carcinoma of the lung is now almost as



frequent in occurrence as carcinoma of the stomach. The increased incidence is probably due to a combination of factors including increased longevity of the general population, increased interest in the disease, and improved methods of diagnosis. Boyd<sup>4</sup> thinks the disease was not recognized twenty years ago because it was not looked for.

It is now generally recognized that 80-85% of lung cancer occurs in men between the ages of 40 and 70.

### Symptoms

Churchill<sup>3</sup> states, "The early symptoms of pulmonary carcinoma are so commonplace that they may not be taken seriously either by the patient or his physician." The early symptoms may be mistaken for bronchitis, asthma, virus pneumonia, tuberculosis, cigarette cough, and other chronic chest conditions. The symptoms usually associated with lung cancer, namely hemoptysis, weight loss, and chest pain, are frequently late symptoms of the disease

### Diagnostic Methods

A detailed discussion of the various methods of diagnosis is not within the scope of this paper.

A presumptive diagnosis can usually be made from X-ray examination alone; however, the centrally located tumors may be obscured by the heart and mediastinal shadows. A comprehensive examination includes lateral films and fluoroscopy in addition to the usual antero-posterior position. At times oblique and grid films may be necessary.

Cytological studies of the sputum in experienced hands have proved useful and reliable. It should be emphasized that a negative study does not prove the non-existence of cancer.

Bronchoscopy gives information regarding the vocal cords, displacement and fixation of the carina, and the exact location of the tumor in the centrally located lesions. In addition, it yields a piece of tissue for microscopic examination.

Exploratory thoracotomy is now established as a safe procedure and should be used without hesitation when the diagnosis cannot be made by other methods. If the lesion is peripheral, a direct biopsy can be obtained; if central within a segment or lobe, the segment or lobe can be removed for examination before proceeding with the more radical resection. Pneu-

monectomy is the operation of choice for carcinoma. In rare instances limited pulmonary reserve will necessitate limiting the resection to a lobe.

### Operability and Operative Mortality

Churchill<sup>3</sup> reviewed nine reports published since 1940, recording 1,950 cases of carcinoma of the lung. In 782 cases (40%) exploratory thoracotomy was done, and in 432 cases resection was performed (22%).

In recent years the operative mortality following pneumonectomy has shown an encouraging decline. Prior to 1940, the operative mortality following pneumonectomy for carcinoma in the larger surgical clinics of this country was reported from 27% to 54%.

In 1947, Ochsner<sup>1</sup> reported a 20% mortality in the past five years. Reinhoff<sup>5</sup> reported a 21% mortality in the last six and one-half years. The mortality figures vary somewhat depending upon the rate of resectability or selection of cases, but the general trend has been toward a lower death rate. Thus in 1947, Jones<sup>6</sup> reported a total of fifty-two pneumonectomies with only two hospital deaths, or a mortality rate of less than 4%. This was accomplished on the basis of performing thoracotomy in 33% of the cases diagnosed, and carrying out pneumonectomy in 20% of the total cases. Adams<sup>7</sup> in 1946, on the basis of a 31.4% rate of resection, recorded a hospital mortality of 3.3% in his last thirty resections. Ochsner states that approximately 50% of the operative deaths are due to cardio-vascular diseases.

### Survival Rates

There are a number of factors which appear to influence the survival rate. The most favorable prognosis is in patients with well differentiated epidermoid carcinoma, the poorest in those with undifferentiated carcinoma. In adenocarcinoma and epidermoid carcinoma, the survival rate appears to be correlated with the degree of differentiation of the tumor. Phillips<sup>8</sup> has recently shown that more than one cell type may be present.

There is some correlation between the size of tumor, the duration of symptoms and the survival rate, but it must be considered with regard to cell type and extension to regional non-resectable structures and distant metastases.

Ochsner<sup>1</sup> in 1948, reported a gross five-year survival rate of 27% of 195 cases in

which resection had been carried out. Many of these were palliative resections with no hope of cure. In those cases which were thought to be curative, the five-year survival rate was 41%.

### Present Series

In the past two years, the author has seen a total of twenty-two cases of lung cancer; sixteen were proved by microscopic examination; six cases were clinically diagnosed advanced carcinoma, but were not proved by biopsy. Exploratory thoracotomy was done in sixteen cases (73%), and resection in eight cases (36%). This is a higher rate of exploration and resection than generally reported; however, it should not be taken as an indication that early cancer is being seen. Many of the exploratory operations were done in order to make a definite diagnosis, with little hope of even a palliative resection. Resection was done on every case in which the tumor could be removed with hope of palliation, even if there was no hope of cure. There were three cases in which a large segment of pericardium had to be removed. One of these also required removing a section of the right auricle of the heart where the tumor had invaded it. This patient was 64 years old at the time of operation. He had symptoms dating back at least two years. He had a large well-differentiated epidermoid carcinoma. He is living with no evidence of cancer at this time, one and one-half years following operation.

CASE 1. F. S., a 54-year-old colored male, gave a history of cough, 20 pounds weight loss, and increasing weakness of 10 months duration. X-ray showed a large mass in the right upper lung. Cytological examination of the sputum showed cells sug-



Fig. 1-A

Case 1. Carcinoma involving a large area of the right upper lobe.

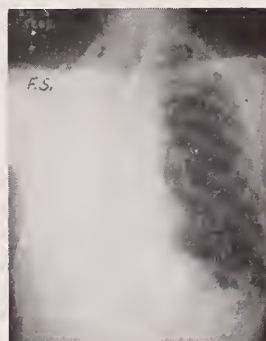


Fig. 1-B

Postoperative film following right pneumonectomy.

gesting lung cancer. Thoracotomy revealed a tumor of the right upper lobe. Pneumonectomy was performed in August 1948. There was no evidence of mediastinal metastases. Pathological examination showed undifferentiated carcinoma. The patient expired 6 months later. Autopsy showed extensive liver metastases. There was no demonstrable carcinoma remaining in the chest.

CASE 2. F. B., a 51-year-old white male, gave a history of cough, purulent sputum, weight loss, and pain in the left chest for 3 years. Bronchoscopy done elsewhere 3 years previously was said to be negative. X-ray showed atelectasis of the left lung with suggestion of areas of cavitation. Sputum examination was negative for cancer cells. Bronchoscopy showed obstruction of the left stem bronchus. Biopsy showed normal bronchial epithelium. Thoracotomy revealed a large tumor around the left stem bronchus. Pneumonectomy was done in January 1949;

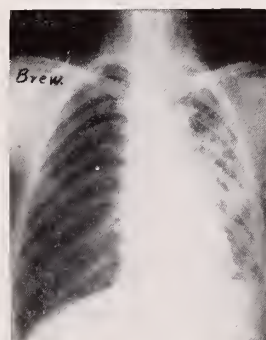


Fig. 2-A

Case 2. Carcinoma of the left stem bronchus with atelectasis and suggestion of areas of cavitation of the left lung.





Fig. 2-B

**Bronchogram showing obstruction of the left stem bronchus in the oblique view.**

metastases were present in the mediastinal nodes. Pathological report: Epidermoid carcinoma, grade 2. The patient expired at home 5 months later. An autopsy was not obtained.

CASE 3. G. W., a 64-year-old white male, gave a history of cough, dyspnea, wheezing, and "asthma" for 2 years. X-ray showed a large area of increased density of the right lower lung. Sputum examination showed cancer cells. Bronchoscopy showed an obstruction of the right lower lobe bronchi, but no biopsy was obtained. Thoracotomy showed a large tumor of the right lower lobe invading the pericardium. Pneumonectomy was performed in April 1949. Intrapericardial ligation of the vessels was done, and excision of an area of the right auricle, about 2½ centimeters in diameter, where the tumor had invaded it. Pathological report: Epidermoid carcinoma, well-differentiated in some areas, undifferentiated in other areas. The patient is living without evidence of cancer 18 months later.

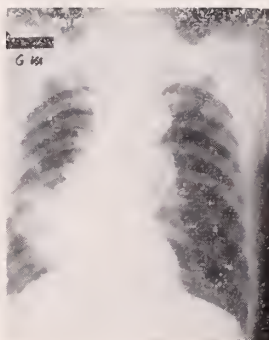


Fig. 3

**Case 3. Carcinoma involving the right lower and middle lobes.**

CASE 4. C. H., a 42-year-old white male, gave a history of cough, chest pain, hemoptysis, and weight loss of 7 months duration. X-ray showed slight shift of the mediastinum to the right with a questionable mass at the right hilum. He was coughing up no sputum at the time. Bronchoscopy showed what appeared to be an extrabronchial mass compressing the stem bronchus. The mucosa was intact at this point. Pneumonectomy, performed in October 1949, revealed a large tumor surrounding the right stem bronchus and extending proximally to within 2 centimeters of the carina. Pathological report: Small-cell undifferentiated carcinoma with metastases to the hilar nodes. A metastatic lesion of the right tibia appeared 7 months postoperatively. The patient is living with metastasis 10 months postoperatively.

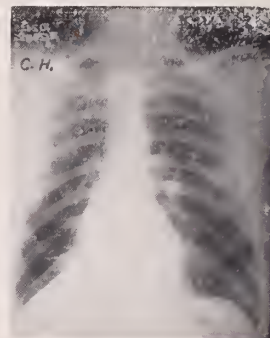


Fig. 4

**Case 4. Carcinoma of the right stem bronchus with atelectasis of the medial segments of the lower lobe.**

CASE 5. M. G., a 58-year-old white female, gave a history of asthma for 4-5 years. She had had cough and 20 pounds weight loss in the past year. Examination showed wheezing sounds over the right lower lung. X-ray was negative. Bronchoscopy was negative. Saline washing from the right lower lobe bronchus showed a small piece of tissue which was thought to be definite cancer tissue. Right bilobectomy was performed in November 1949, removing the lower and middle lobes. Pathological examination showed 2 small masses 3-4 millimeters in size in a secondary bronchus of the right lower lobe, which were interpreted as being early low-grade epidermoid carcinoma with no evidence of regional metastasis. This patient is living and well 11 months postoperatively.



Fig. 5

Case 6. Carcinoma of the left apex invading the chest wall.

CASE 6. E. W., a 55-year-old white male, gave a history of pain in the left upper chest for 9 months. He had had no cough or sputum. He had lost weight. X-ray showed an area of increased density in the left upper lung. Bronchoscopy was not done. No sputum was available for cytological study. Thoracotomy, done in June 1949, revealed a tumor of the left upper lobe invading the chest wall. Mediastinal nodes also were involved. A local wedge resection of the involving lung and adjacent chest wall was carried out. Pathological report: Epidermoid carcinoma, grade 4. The patient developed signs of metastasis to the brain before leaving the hospital, and expired at home 6 weeks postoperatively.

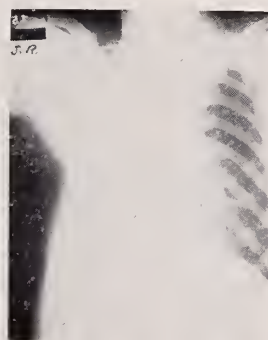


Fig. 6

Case 7. Malignant adenoma of the right stem bronchus with complete atelectasis of the right lung. This was first diagnosed adenoma of the bronchus, cylindroma type. At operation it had invaded the pericardium and had metastasized to a lymph node. This patient later came to autopsy and was found to have a metastatic lesion in the right and left kidneys.

CASE 7. J. R., a 58-year-old colored male, had loss of weight and strength, and chest pain for 1 year. He had had a septic course in the hospital in spite of antibiotics. X-ray showed atelectasis of the right lung. Cytological study of the sputum was negative. Bronchoscopy showed a mass obstructing the right stem bronchus. Biopsy report: Adenoma of the bronchus (cylindroma type). Thoracotomy was performed in March 1950. The lung was found to be densely adhered to the chest wall. Multiple abscess cavities were evacuated in freeing the lung. Due to the poor condition of the patient at this time, the operation was terminated and the infected pleural cavity drained. Pneumonectomy was performed in April 1950, by means of intrapericardial ligation of the vessels. Pathological report: Adenocarcinoma, grade 1, of the right stem bronchus, with invasion of the pericardium and one hilar lymph node. The postoperative course was septic with empyema. The patient expired 39 days postoperatively. Autopsy showed empyema, pericarditis, and pneumonia in the left lung. A small area of metastatic tumor was found in each kidney, which had the same relatively benign appearance of the original tumor.

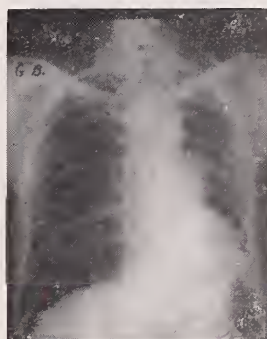


Fig. 7

Case 8. Carcinoma of the left lower lobe bronchus with atelectasis at the left base.

CASE 8. G. B., a 47-year-old white male, gave a history of cough, hemoptysis, weight loss, and weakness increasing over a period of 1 year. He had acute onset of dyspnea and left chest pain associated with a fall shortly before hospitalization. X-ray showed atelectasis of the left lung. The apex expanded within a few days. Bronchoscopy showed a tumor obstructing the left stem bronchus. Biopsy con-



firmed the diagnosis of carcinoma. Thoracotomy revealed an 8-centimeter tumor of the left hilum invading the pericardium. Pneumonectomy was performed in July 1950, by means of intrapericardial ligation of the hilar vessels. Limited thoracoplasty was done at the same time, removing parts of the third through the seventh ribs. The patient was alive and well 2 months postoperatively.



Fig. 8-A

Case 9. Large lung abscess involving a large area of the right lower lobe.

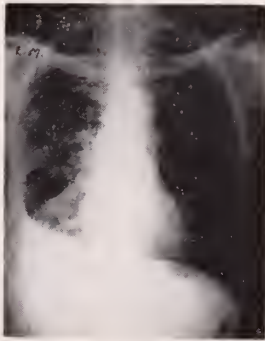


Fig. 8-B

Following right lower lobectomy.

### Lung Abscess

Pulmonary abscess may result from either infected vascular emboli or from bronchial aspiration. The majority of single abscesses probably result from aspiration. Prior to the use of the antibiotics, approximately 20% of the acute abscesses were thought to heal spontaneously (Churchill<sup>9</sup>). This figure has been increased by the proper use of the antibiotics. Healing rarely occurs, however, unless definite regression occurs within six weeks of the onset.

### Chronic Lung Abscess

Drainage has been the accepted treatment of chronic abscess until a few years ago. The results were far from satisfactory. In 1939, Churchill<sup>9</sup> stated, "Drainage by no means ends the story in many cases. Sequestration of the lung commonly results in a defect that resists the process of natural healing. In some cases the defect may be closed by turning muscle grafts into the cavity. Apical cavities may be aided by thoracoplasty. It is becoming increasingly clear that the large defects must be treated by lobectomy or pneumonectomy."

In 1948, Shaw and Paulson<sup>10</sup> reported a series of 52 patients with putrid abscess of the lung who were treated by pulmonary resection. The results were considered satisfactory in 82.7%. The mortality was 3.8%. This was compared with a previous series of 33 patients treated by drainage; 57.6% of this group were considered well following treatment. The mortality was 15.2%.

Kent and Ashburn<sup>11</sup>, also in 1948, reported 30 cases of chronic lung abscess treated by pulmonary resection. There were two operative deaths (6.6%); there were two bronchial fistulae with small empyema cavities which were satisfactorily closed, and one persistent bronchial fistula. The remaining patients had no complications and were considered well.

### Present Series

CASE 9. L. M., a 62-year-old colored male, gave a history of chronic cough productive of purulent sputum for 8 months. Several months after the onset he was found to have a small empyema filled with "foul-smelling" pus. This was satisfactorily treated with aspiration and penicillin injection by his referring physician. He improved temporarily, then an area of increased density of the right lower lobe was seen to be increasing in size. This was associated with increased productive cough and signs of sepsis. Cytological study of the sputum showed inflammatory cells only. Bronchoscopy showed inflammation of the lower lobe bronchi. Thoracotomy was performed in July 1949. A large abscess of the apical segment of the lower lobe was found with multiple smaller abscesses throughout the lower lobe. The lobe was removed. A small empyema developed which was satisfactorily treated with aspiration and

injection of penicillin and streptomycin. The patient is living and well at present, 15 months postoperatively.



Fig. 9

**Case 10.** Right lateral view following injection of iodized oil shows a triangular area of increased density in the posterior apical segment of the lower lobe.

**CASE 10.** A. C., a 21-year-old white male, had dirty foul-smelling cavernous teeth. One of the teeth had been extracted with local novocaine anesthesia 2-3 months previously. For 6 weeks he had noted a cough productive of 2-3 cups of foul purulent sputum daily. The patient had anorexia and weight loss. X-ray showed an abscess of the right hilar region about 4 centimeters in diameter with a fluid level. Antibiotics in large doses for 10 days resulted in no appreciable change in the abscess. Bronchoscopy showed pus draining from the posterior apical segment of the lower lobe. Bronchograms showed no evidence of bronchiectasis. Thoracotomy was performed in August 1950. A thick-walled abscess was found in the superior apical segment. This segment was ex-



Fig. 10

**Case 11.** Bronchogram, right posterior oblique, showing bronchiectasis limited to both segments of the right middle lobe.

cised, leaving the remainder of the lower lobe. Convalescence was uncomplicated. The patient appears to be well at this time. The lung is well expanded and he is bringing up no sputum.

### Bronchiectasis

There are three fairly distinct types of bronchiectasis. First and least common are those which are thought to be congenital in origin. These show diffuse involvement of all segments of an entire lung or sometimes all segments of both lungs. Second are those cases which occur secondary to obstruction of a bronchus. Third and most common are those cases which involve one or more small segments of the lung. This type is characteristically a disease of youth. Perry and King<sup>12</sup>, in reviewing 400 cases followed at Massachusetts General Hospital, found 42% began in the first decade and 69% before the age of 20 years.

Atelectasis is thought to be the important factor in the production of bronchiectasis. The mechanism by which atelectasis produces bronchial dilatation has been discussed in detail by Andrus<sup>13</sup>. With collapse of pulmonary parenchyma, a potential space is created within the pleural cavity. The negative intrapleural pressure increases from normal -4, -6, to as much as -30, -40 millimeters of mercury. The diaphragm rises, the mediastinum shifts and the neighboring pulmonary tissue over-expands. This negative pressure is also transmitted through the solid non-expanded pulmonary tissue to the elastic and expansible bronchial walls. The bronchi dilate and remain dilated for the duration of the atelectasis. If infection of the bronchial wall supervenes, bronchiectasis results. "Reversible" or "pseudobronchiectasis" is probably atelectasis in which there has not been sufficient infection to destroy the bronchial wall.

### Symptoms

The symptoms may be so mild or atypical they are frequently unrecognized, being attributed to anemia, undernourishment, bronchitis, asthma or tuberculosis. Alexander<sup>14</sup> states, "There are many bronchiectasis patients in tuberculosis sanatoria in whom tubercle bacilli have never been found in the sputum, and good bronchograms have never been made." Many physicians think of bronchiectasis only in association with a productive cough and foul-smelling sputum.



### Diagnosis

Absolute diagnosis depends upon complete iodized oil bronchograms. This is best done by introducing a catheter into the cocaineized trachea and introducing the iodized oil into all segments of the lung. This is usually done at one sitting unless the pulmonary reserve is greatly diminished. The success of bronchography depends most of all on the co-operation of the patient in not coughing; therefore, it is usually not satisfactory to do a bronchogram immediately following bronchoscopy. A poor or incomplete bronchogram must be repeated as the entire bronchial tree must be outlined to determine the extent of the disease before surgery can be considered.

### Treatment

Surgery is the treatment of choice for those patients who have definite irreversible bronchiectasis, providing there will be enough normal lung tissue remaining after excision of the diseased segments. In 1944, Alexander stated that lobectomy was then safe, but only about 50% of bronchiectasis was suitable for surgery. The unsuitable cases include those with extensive involvement of many segments of both lungs, the older age group, and those who have other medical conditions which prevent major surgery.

### Segmental Resection

Churchill and Belsey<sup>15</sup> first stressed the importance of segmental resection in bronchiectasis, especially in regard to the lingular segment of the left upper lobe. Overholt<sup>16</sup> has further emphasized the value of this procedure and has applied it to other segments of the lung. The application of segmental pulmonary resection is dependent upon an accurate knowledge of the anatomy of the bronchi and vessels to the various segments. Each lobe has a number of segments and each segment is a distinct anatomical unit which can be removed without sacrificing the adjacent normal segment. This procedure is particularly applicable to bronchiectasis, but may be used for other non-malignant diseases.

### Mortality

In 1936, Churchill<sup>17</sup> reported 49 cases of pulmonary resection for bronchiectasis with a mortality rate of 6.1%. The last 30 successive cases were done without any deaths. Since that time there have

been a number of reports of over 100 successive lobectomies with no deaths.

The first bilateral lobectomy for bilateral bronchiectasis was done by Eloesser<sup>18</sup> in 1933. Since that time, especially in the past eight years, there have been a number of reports of small series of bilateral resections. The largest series is that of Kergin<sup>19</sup> who reported 94 resections in 58 patients with 4 deaths, an operative mortality of 4%.

### Present Series

CASE 11. L. B., a 36-year-old white male, gave a history of "virus pneumonia" in January 1949. He had had a chronic cough since then, productive of about  $\frac{1}{2}$  cup of purulent sputum daily. He had had hemoptysis on one occasion. X-ray showed slight increase in bronchovascular markings on the right. A bronchogram outlining all segments showed bronchiectasis limited to the right middle lobe. Thoracotomy and a right middle lobectomy was performed in November 1949. The patient made an uneventful recovery and has been well now 11 months.



Fig. 11

CASE 12. Right lateral bronchogram showing obstruction of the right middle lobe bronchus about one centimeter distal to its origin. The patient had bronchiectasis of the middle lobe with sudden occlusion of the bronchus to the middle lobe (middle lobe syndrome).

CASE 12. F. H., a 43-year-old colored male, gave a history of chronic, slightly productive cough for 6 months. He had sudden onset of right chest pain 2 hours before admission. Examination and X-ray showed signs of atelectasis of the right middle lobe. He had moderate temperature elevation which gradually subsided with antibiotic therapy in 1 week. Large quantities of clear yellow fluid were aspirated from the chest at first,

then none could be obtained. Bronchoscopy showed the visible bronchi to be negative. A bronchogram showed complete obstruction of the right middle lobe bronchus with partial collapse of the upper and lower lobes. Thoracotomy was performed in May 1950. A large quantity of thick fibrinous exudate was found in the pleural cavity with about 50% collapse of the lung. A thick fibrinous capsule prevented expansion of the lung. Decortication allowed the upper and lower lobes to expand. The middle lobe was found to be completely collapsed with multiple abscesses throughout the lobe. Middle lobectomy was performed. A ring of firm enlarged lymph node was found obstructing the middle lobe bronchus. Bronchiectasis was found throughout the middle lobe. The sudden occlusion of the middle lobe bronchus by the hilar nodes has been referred to as the "middle lobe syndrome" by Graham. The patient made an uneventful recovery and has continued well since operation.

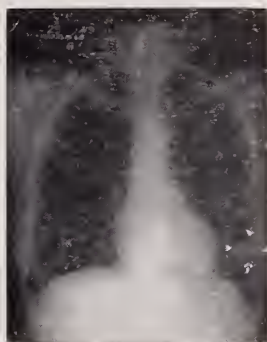


Fig. 12

**Case 14.** X-ray showed a fairly well-circumscribed area of increased density at the left base. This proved to be an area of atelectasis distal to a bronchus obstructed by a broncholith.

**Case 13.** B. H., a 70-year-old white male, gave a 4 months history of cough, hemoptysis, and weight loss. He had an acute onset of severe pain in the right chest, followed by fever. X-ray showed consolidation of the right middle lobe. Bronchoscopy was negative. A bronchogram showed no filling of the middle lobe. Thoracotomy was done in September 1948, revealing consolidation of the middle lobe. Lobectomy was performed. The postoperative course was complicated only by delayed expansion of the lower lobe. Pathological examination showed chronic inflammation, fibrosis, and bronchiectasis



Fig. 13

**Case 17.** Bronchogram showing extensive dilation of all segments of both lungs. This is thought to be a congenital bronchiectasis.

The patient has been well since operation except for slightly productive cough.

**Case 14.** F. C., a 45-year-old white female gave a history of 10 pounds weight loss in the past 6 months, and several large hemoptyses 3 weeks before hospitalization. X-ray showed a fairly well-circumscribed area of increased density at the left base. Cytological study was negative for cancer cells. Bronchoscopic examination was negative. Acid-fast examinations were negative. Thoracotomy was done in October 1949. The mass could be felt in one of the anterior basal segments of the lower lobe. Segmental resection was done and frozen section of the mass showed inflammatory tissue. More careful examination of the specimen later showed a broncholith in the bronchus of the segment. Except for delayed expansion of the lower lobe, the postoperative course was uneventful and she has been well since operation.



Fig. 14

**Case 18.** Bronchogram, oblique, showing extensive saccular bronchiectasis apparently involving all segments of the left lung, probably congenital type of bronchiectasis. The right lung showed no bronchiectasis.



CASE 15. B. T., a 59-year-old white male, gave a history of repeated attacks of right chest pain with productive cough over a period of 2-3 years. There had been 30 pounds weight loss. X-rays by the referring physician showed atelectasis on the right. X-ray showed an area of increased density of the right upper lobe and at the hilum on the right. Cytological examination was negative for cancer cells. Thoracotomy revealed a firm mass 5 centimeters in diameter present in the upper lobe. There were many emphysematous bullae over the surface of the lung. Pneumonectomy was performed in July 1949. Pathological examination showed the mass in the upper lobe to be an inflammatory mass distal to an obstructed bronchus. There were numerous areas of pneumonitis and fibrosis. The immediate postoperative course was uncomplicated. Subsequently he has had moderate dyspnea on attempting any ex-

ertion. This patient has emphysema of the remaining lung and has recently had a thoracoplasty on the right side to diminish the over-expansion of the remaining lung.

CASE 16. R. R., a 15-year-old boy, sustained a shotgun wound to his left chest at close range. The wound was debrided and closed by his referring physician. He developed a wound infection which resulted in an open pyopneumothorax. Thoracotomy and decortication was performed in March 1949. At this time an area in the lower lobe about 3 x 2 inches in size was found to be collapsed, fibrotic, and contained lead shot. A wedge resection of this area was done. The chest wall was reconstructed by shifting muscle and skin flaps. The postoperative course was complicated by development of a small empyema which was drained with satisfactory recovery. He has continued well to the present time.

### Bronchiectasis Not Treated Surgically

CASE 17. E. D. C., a 59-year-old white female, gave a history of repeated pulmonary infections for many years. She had been diagnosed, asthma, emphysema, and heart disease. Bronchograms showed extensive bronchiectasis throughout all segments of both lungs. Fluoroscopy at the time the bronchi were filled with iodized oil showed rhythmical contraction of the dilated bronchi, showing that the normal function of the wall was not destroyed as it is in acquired bronchiectasis. This probably explained why this patient has done as well as she has with such extensive bronchiectasis.

CASE 18. E. B.: This 26-year-old white male was told he had pneumonia of his left lung at age 4. Since then he had had repeated respiratory infections, and cough productive of foul sputum at times. He had had hemoptysis on several occasions. He had been diagnosed tuberculosis without finding tubercle bacilli in the sputum, and a left phrenic section had been done. Bronchography showed extensive saccular bronchiectasis of all segments of the left lung. Repeated examinations of the sputum for tubercle bacilli were negative. This patient probably has congenital bronchiectasis in view of the extensive involvement of all segments of one lung. Pneumonectomy was advised in view of the extent of the disease and the disability resulting from it.

CASE 19. R. S., a 23-year-old white female, stated she had had a chronic cough

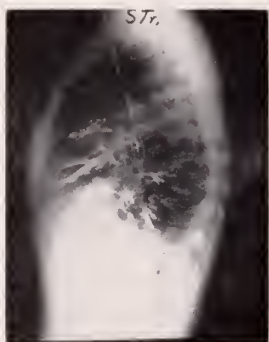


Fig. 15-A

Case 19. Right lateral bronchogram showing bronchiectasis of all segments of the lower lobe, the middle lobe, and the anterior segment of the upper lobe.

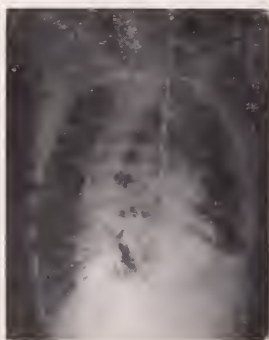


Fig. 15-B

Left posterior oblique showing extensive bronchiectasis of the segments of the lower lobe, and the lingular segment of the upper lobe.

## PULMONARY RESECTION

TOTAL PATIENTS    OPERATIVE DEATHS    HOSPITAL DEATHS

## PNEUMONECTOMY

Carcinoma .....	11	0	1 (6 Weeks)
Inflammatory Disease ...	2	0	0

## LOBECTOMY

Carcinoma .....	3	0	0
Inflammatory Disease ...	12	0	0

## SEGMENTAL RESECTION

Inflammatory Disease .....	7	0	0
	<hr/> 35	<hr/> 0	<hr/> 1

productive of yellow sputum for 3-4 years. She had previously been diagnosed as having a lung abscess. She was coughing up 1-2 cupsful of putrid sputum daily on admission. Bronchography showed extensive bilateral bronchiectasis involving the right lower, middle and antero-lateral segments of the upper lobe. There was also extensive bronchiectasis of the left lower lobe and lingular segment of the left upper lobe. This patient has been advised to have resection of the segments most markedly involved.

## Summary

1. A discussion of the development and present concept of the treatment of pulmonary carcinoma, lung abscess and bronchiectasis has been given.

2. Brief case reports and the results to date are presented of sixteen consecutive patients undergoing pulmonary resection for carcinoma or inflammatory disease of the lung.

## ADDENDUM

Since submitting this paper for publication, 19 additional cases of pulmonary resection have been done. The summary of these cases has been included in the above chart.

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## EAR PAIN AND ITS RELATION TO COSTEN'S SYNDROME

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COVINGTON

Every week the average general practitioner or laryngologist examines one or two patients who have some indefinite ear complaint or pain in the vertex of the head for which no objective signs can be found. In the past and at the present time, many of these cases were classified as just a case of "nerves" (a word of comforting vacuity). These symptoms plus logical thinking by various men finally associated them with the temporomandibular joint.

Ear and associate symptoms consequent upon temporomandibular joint abnormality were brought forth by James B. Costen, M. D., St. Louis, Missouri, in 1933. Earlier writers such as Edward C. Kirke, D. D. S., and David Goodfriend, D. D. S., during the years from 1925 to 1930, expressed a consciousness of the symptoms related to temporomandibular joint movement.<sup>1</sup>

### Etiology and Pathogenesis

The pressure upon, and anatomical distortion of, the temporomandibular joint and adjacent structures is dependent on actual destructive changes. These destructive changes in the temporomandibular joint are brought about by undue and unnatural pressure on the meniscus, glenoid fossa, and condyle or head of the mandible. This pressure may be of a type due to acute or chronic trismus, i. e., the tonic contraction of the muscles of mastication<sup>2</sup>. The complete loss of molar teeth invites destruction of the mandibular joints<sup>3</sup>.

Other causes of trismus listed by Costen are: yawning, biting of an apple, a blow on the chin, stretching of the jaws under anesthesia, ulcerated tooth, peritonsillar abscess, parotitis, psychoneurosis, fracture of the jaw, ill-fitting dental plates, impacted unerupted teeth, malocclusion, and habit of removing dentures.

### Symptoms

As a rule the patient presents one or a number of the symptoms as follows: (a) pain, dull in type, within and about

the ears; (b) tinnitus, usually "low buzz" in type, less often a snapping noise when chewing; (c) stuffy sensation in ears, pronounced about meal times; (d) mild catarrhal deafness which is relieved by inflation of Eustachian tubes; (f) tenderness by palpation on the temporomandibular joints; typical sinus headaches after sinus or eye involvement has been corrected or found to be non-existent; (g) traumatic, noisy, painful, limited or excessive movement of the temporomandibular articulation; (h) neuralgia; (i) a burning or prickling sensation of the tongue, the throat, side of the nose, accompanying this sensation slight herpes of the affected part may be present; (j) a feeling of dryness of the mouth, due to disturbed function of the salivary glands; (k) a feeling of fullness in the nasopharynx<sup>1</sup>.

By glancing over the preceding paragraph it is easy to realize that one may find it difficult to make a diagnosis unless he has the Syndrome of Costen in mind.

### Anatomico—Physiological Grouping of Symptoms

Most of the symptoms come under one or the other of these headings: (a) neurological, (b) otological, (c) muscular<sup>1</sup>.

The neurological symptoms are largely dependent upon the close relationship existing between the temporomandibular joint and two nerves, the auriculotemporal nerve and the chorda tympani.

As we know the auriculotemporal nerve arises from the mandibular nerve by two roots. These two roots communicate with the otic ganglion (directly) and the glossopharyngeal nerve (indirectly). The auriculotemporal nerve then passes posteriorly just medially to the neck to the condyle, thence to the parotid gland, and superiorly to the temple over the zygoma. It is finally distributed as a cutaneous nerve of the temple and scalp and reaches almost to the vertex of the skull. When it is adjacent to the neck of the condyle, the nerve gives off a branch to the temporomandibular joint. Irritation of this nerve is possible for the following two reasons: fibers of the nerve actually enter

the joint structure, unsupported movements of the condyle, posteriorly or mesially, causes trauma as the nerve passes close to the mesial side of the joint capsule. Irritation of the auriculotemporal nerve by impaction of the condyle is the chief etiological factor in glossodynia or burning tongue.

The chorda tympani, a branch of the facial nerve, is even more closely related to the movements of the condyle than the auriculotemporal nerve. This nerve enters the tympanic cavity, passes over the tympanic membrane and the handle of the malleus, and leaves the cavity through the mesial end of the petrotympanic fissure to reach the infratemporal fossa. Under cover of the external pterygoid muscle the chorda tympani receives a branch from the otic ganglion and incorporates itself into the lingual branch of the mandibular nerve. The chorda tympani supplies a root to the submaxillary ganglion, and is finally distributed to the side and dorsum of the tongue in its anterior two-thirds, thus giving rise to the sense of taste.

The otological symptoms may be explained in the following manner. On the labyrinthic wall of the tympanium, is an important plexus, the tympanic plexus, formed by the caroticotympanic nerves, the tympanic branch of the glossopharyngeal nerve, and a twig from the geniculate ganglion of the facial nerve. Remembering the relationship between the tympanic plexus and the facial, glossopharyngeal and trigeminal nerves, together with the actual passage of the chorda tympani nerve through the tympanic cavity, we are more able to appreciate the phenomenon of tinnitus and aural symptoms in cases of Costen's syndrome and pain of dental origin is referred to the ear.

In considering the muscle symptoms we should look more at the functional inter-relationship existing between various combinations of muscles. George Christensen, D. D. S., of Queensland, listed seven anatomical facts relative to alteration in the position of the mandible. These facts are of interest to the practitioner and the dentist who is interested in the problem of the loss of vertical dimension.

These points are as follows:

(1) The tensor veli palatini muscle which is the muscle directly associated with the opening of the lumen of the tube;

(2) the salpingopharyngeus is concerned with alteration of the angle between the cartilaginous portion of the tube and the bony portion and helps establish patency; (3) the opening of the mouth and depression of the mandible are accompanied by the contraction of the external pterygoid muscles, which pull the head of the condyle forward, the sphenomandibular and stylomandibular ligaments then come into play to fix the ramus, the mandible then rotating in the region of the mandibular foramen. (4) the stylomandibular ligament passes in close approximation to the junction of the cartilaginous and bony portions of the Eustachian tube and is capable of occluding the tube at this point; (5) displacement of the condyle medially can result in compression of the tube, the pressure being transmitted via the head of the external pterygoid and intervening soft tissues; (6) the internal pterygoid is associated with the closure of the jaw, the extent of closure being limited by occlusion of the teeth. In the cases of closed bite, the contraction distance of the internal pterygoid is decreased, its action hampered, and, as a result, it may bulge medially and posteriorly along the superior head of the external pterygoid affecting the cartilaginous portion of the tube, resulting in compression; (7) in cases of closed bite all the muscles and tissues of the posterior wall of the pharynx are in a loose placid state, muscle tone being considerably diminished<sup>2</sup>.

The Eustachian stenosis consequent upon malposition of the mandible can be relieved by re-establishing correct vertical dimension, and the ventilation of the middle ear is thereby improved.

### Diagnosis

The diagnosis depends upon history, gross findings, roentgen study and test of treatment.

Symptoms were discussed earlier in the paper. Gross findings as loss of molar teeth on one or both sides, over closure or maloccluding natural teeth or ill-fitting dental plates, uneven movement of the lower jaw on opening and closing, crepitus within the mandibular joints, tenderness of the mandibular joints to internal palpation (index finger palpation posterior to last molar inside the mouth), presence of trismus.

X-ray findings: density changes in the mandibular joint structures, narrowing of spaces between the condyle and glenoid



fossa, either uniform or asymmetric, widening of joint spaces and wide excursion of the condyles in the open position, fixation of one condyle against the tubercle and normal excursion of the opposite condyle, erosion of the anterior surface of the condyle and posterior aspect of the articular tubercle, change in the normal contour of glenoid fossa and other condyle, but with normal bone surfaces (suggestive of abnormal stress), fracture of the tympanic plate, impacted unerupted third molar teeth.

Test of treatment consists in opening the bite by the use of cork discs of accurate uniform thickness in the molar area or by temporary dental appliques. The cork discs are inserted into the molar area by the patient and are tested in place while an elastic head gear is applied to fit the jaw. The patient keeps a record and by trial and error arrives at the correct number of discs necessary to relieve the symptoms. The discs may be required on both sides or just on the one side<sup>5</sup>.

### Treatment

A most important feature in the treatment is the fixation of the lower jaw by an elastic chin strap, and its leverage on

the temporary or permanent molar support<sup>4</sup>. However, in the treatment of Costen's Syndrome the final arbiter is the dentist; the general practitioner and otolaryngologist are very passively concerned.

### Comment

No attempt at originality is made. The purpose of the paper is to freshen the readers' minds concerning temporomandibular joint disease. It is only when we have the Costen's Syndrome in mind that we are able to recognize the condition.

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## ACUTE APPENDICITIS

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Surgery has always been a dynamic art and science in all its specialties. Complex operative procedures become common place. Newly discovered drugs are quickly utilized as useful adjuncts. The horizon of lowered mortality constantly broadens. This is properly so. In our haste to improve, however, we should not allow accomplishments of the past to deteriorate.

One of the outstanding achievements of the last fifty years is the control of appendicitis. Its diagnosis as well as its treatment had to become recognized and established. Mortality seemed to have reached an irreducible minimum and then the antibiotics were introduced with most gratifying favorable results. This disease had apparently become one that was practically completely controllable. Many of us were so confident of the fact that even a sketchy analysis of the death rate of appendicitis in Kentucky gives us a tremendous shock.

### Mortality Rate

In the 9 years beginning January 1, 1940 and ending December 31, 1948 there were 1,495 deaths, an average of 166.1 a year. In spite of a remarkable drop from 287 the first year to 77 the last year, that figure still represents by far too many unnecessary deaths. It is accepted with an amazing complacency when it is realized that a terrible panic occurred when polio that same year caused only 10 deaths, meningococcic meningitis only 35 and encephalitis only 11.

### Factors Responsible For Mortality Rate

There are probably many factors responsible for these appendicitis deaths. In spite of educational programs, patients still purge for pain without benefit of medical consultation. In other cases, it is possible that the physician who gave castor oil for abdominal pain and diagnosed the case as appendicitis, if it was not relieved, has as his successor, the enthusiast whose confidence in antibiotics has persuaded him that night emergency appendectomies are entirely unnecessary. At other times, the law of averages is

ignored and the possibility of the most common acute intra-abdominal lesion is not adequately considered.

### Incidence and Etiology

Appendicitis is primarily a disease of young adults but it may occur at any age and in 1948 caused deaths below 1 as well as over 80 years of age. Since no reasonable cause for appendicitis has been demonstrated, there are no prophylactic measures available. It is, therefore, apparently safe to assume that the number of new cases per 100,000 population each year, will continue fairly stabilized at the present rate.

### Pathology

Even though the initiating etiological factor is unknown, the pathological changes resulting are well understood. They will be manifested either by a true infection of the wall of the appendix or by an obstruction of its lumen. The former occurs more frequently, gives rise to the red tense inflamed appendix and develops more slowly. The obstructed type usually due to a fecolith is more rapid in its progress; early gangrene is the rule and perforation is more common.

In considering the pathology of appendicitis, it is impossible to divorce the subject of peritonitis. If leakage occurs early either through a distinct perforation or seepage through a thin necrotic wall, there will be peritoneal contamination which may amount to nothing more if prompt surgery is done. Otherwise, a spreading peritonitis may develop. On the other hand, if leakage is delayed, a protective wall may be formed and an appendiceal abscess develop. It is most important to try to differentiate which is occurring.

### Symptoms

No other disease offers more diagnostic symptoms than does the typical case of appendicitis. Simply because repetition is the greatest teacher, they will be discussed again, and it must be emphasized that the sequence of the symptoms is as important as the actual symptoms themselves. There is, first, rather persistent abdominal



pain, usually periumbilical or generalized. The pain is followed by nausea usually with some vomiting. If the nausea is mild, it may be evidenced largely as anorexia. Rarely do patients with appendicitis have any desire for food. After the nausea there is gradually localization of the pain and especially tenderness in the right lower quadrant. The temperature is generally elevated only one or two degrees. Constipation is the rule but normal stools or, rarely, diarrhea may occur.

Unfortunately, there are many cases with a typical symptom. Even an examiner with considerable experience will consistently meet with cases that are most perplexing.

### Signs

The outstanding physical findings are fever, elevated pulse rate and abdominal tenderness, rigidity or mass.

In uncomplicated appendicitis, the temperature is usually only a degree or two above normal and in many cases is even less than that. The pulse rate, too, will show only a moderate elevation, 10 to 20 additional beats per minute being the usual rise.

The abdominal findings are generally more pronounced. Tenderness is quite definite in degree and in location at McBurney's point. This tenderness, of course, is subject to variation in location if the appendix shows an abnormal location, retrocecal, pelvic, etc. Rigidity due to spasm of the overlying muscles is generally in keeping with the degree of tenderness. One sign I have found of particular value in unruptured appendices is the obverse rebound sign where pressure in the left iliac fossa when quickly released will cause pain in the region of the appendix.

Generalized rebound tenderness usually means diffuse peritoneal irritation or inflammation. There are some who attach importance to hyper-esthesia of the skin overlying the appendix but I have never found this sign of much value.

Rectal examination may elicit tenderness when a pelvic appendix is inflamed and shows little or no abdominal findings.

Vaginal examination is, of course, important in determining the presence or absence of tubal involvement.

No physical examination would be complete without determining the chest findings. In children especially, pneumonia

of the right base may give a very confusing picture.

Peritonitis will show distention with generalized tenderness and rigidity. An appendiceal abscess will show a mass often with fairly normal findings elsewhere in the abdomen.

### Laboratory Findings

The most important laboratory finding is the white and differential blood count. The total of the white blood cells is usually around 12 to 15,000. Higher counts should be looked upon with suspicion although some ranging to 30 or 40,000 have been reported. With the increase in the white count, there is usually some increase in the percentage of polymorphonuclear cells, and this latter may occur with a practically normal total in severe cases with low resistance.

The principal importance of the urine examination is the demonstration of the presence or absence of pus cells. If present, pyelitis, of course, must be ruled out.

Other laboratory findings in the case of acute appendicitis are generally incidental and not significant.

### Diagnosis

The history and physical findings will generally give a very definite lead to the diagnosis. In reaching it, some of the commoner diseases to be eliminated from consideration are acute cholecystitis, pneumonia, pelvic cellulitis, pyelitis and mesenteric adenitis. The latter often presents much difficulty in children. Perhaps the chief aid in differential diagnosis is the relative absence of rigidity in mesenteric adenitis even though the tenderness is rather definite.

In spite of careful study, there will still be many doubtful cases. While there is no defense for the careless physician or surgeon who decides upon operation to play safe in cases that have not been carefully observed, no apology is necessary when surgery is decided upon after thorough study with inconclusive results. The tremendous increase in mortality in cases of missed diagnosis with late surgery is a risk that should not be assumed.

### Treatment

Since appendicitis cannot be prevented, there are no prophylactic measures to institute so far as the actual disease is concerned. There are, however, two important things that can be done to

limit the complications which are the lethal factors of appendicitis.

In the first place, each of us must carry on a one-man educational campaign impressing those with whom we come in contact, of the dangers of catharsis in the presence of abdominal pain.

In the second place, we must set a good example to the patient and refuse to prescribe for abdominal pain without examining patient. Any patient whose pain is persistent or severe enough to impel him to seek medical aid is entitled to the benefit of a careful examination. The responsibility of undue delay on our part in this regard is a serious one.

In discussing treatment, once the disease is established, the various stages it presents should be considered separately.

Regarding early acute appendicitis, there would seem to be little difference of opinion. Prompt appendectomy, even before the use of antibiotics, had achieved phenomenal results with mortality practically nil. Yet, there are responsible authorities who suggest that acute appendicitis is often self-limited and that antibiotics can be satisfactorily dependable for treatment or for delay in surgical intervention. The ones most highly recommended, penicillin and aureomycin, are of great value but only as adjuncts. Their use for replacing or delaying surgery in early acute appendicitis is unjustifiable.

When there is a spreading peritonitis, many surgeons feel that antibiotics are the treatment of choice since rupture has already occurred and surgical trauma may offer additional insult. My practice, however, is to follow those who use antibiotics and parenteral fluids but proceed with appendectomy except in the apparently moribund case. I feel that the peritoneum can take care of a large amount of infection but not a continuing supply. In other words, it is not spillage but leakage that proves fatal.

The last type of case is that where definite abscess formation has occurred. In many of these cases, I have established drainage and tried to remove the appendix if it did not entail too much manipulation. The trend, however, seems to be to follow a plan of watchful waiting. It is felt that the mere walling off of the abscess shows an ability to overcome the infection and that if antibiotics are given, the condition will subside and an interval appendectomy may be safely done.

So far as the operation itself is concerned, I think that it is of little importance what type of incision is used and whether or not or how the appendiceal stump is inverted.

The old McBurney incision is quite adequate and especially in males has proved very satisfactory. Contrary to rather general opinion, it is not, however, immune to hernia formation. The transverse of Davis incision is useful and perhaps lends itself better to enlargement than does the McBurney. An incision I like particularly for females, is a right paramedian, where the muscle is retracted laterally without damage to its nerve or vascular supply. Whether one uses silk, cotton or catgut, the patient can be ambulatory the next day.

I prefer to bury the stump but so many do not that it apparently is not necessary. However, this is the only instance in intestinal surgery where mucosal apposition alone is depended upon.

Drainage is still a debatable procedure. It seems reasonable to me to use it in only two situations. If there is doubt regarding the closure of the appendiceal stump with the possibility of a fecal fistula or if there is so much free purulent fluid that an abscess in the rectovesical space or cul-de-sac appears likely, drainage may avoid serious complications. If a drain is used, it had better be brought out through a stab wound.

Intraperitoneal use of the sulfonamides appears unnecessary when they can be so much better controlled when given by other routes.

Anesthesia will depend upon the anesthesiologist available, the condition of the patient and to some extent, upon the patient's preference. I do not insist upon spinal anesthesia against the patient's wishes except when he is a vigorous husky person with a thick abdominal wall and evidences of a spreading peritonitis. Inadequate relaxation with inhalation anesthesia in that type of case can prolong the operation and add to its trauma materially.

### Summary

Attention has been called to the considerable and largely avoidable mortality of appendicitis in Kentucky.

The classical symptoms and signs of generalized pain followed by nausea and vomiting with later localization of the



pain and tenderness in the right lower quadrant have been reviewed.

The importance of educating the public to avoid the self-prescribing of cathartics in the presence of abdominal pain has been stressed.

The physician has been urged to examine the patient's abdomen before prescribing when there is persistent pain.

The value of early surgery has been reiterated.

The recognition of antibiotics as adjuncts to treatment has been accepted but it has also been emphasized that appendicitis is primarily a surgical disease.

Remember, in closing, that early surgery eliminates the mortality of appendicitis (with the exception of the irreducible mortality of any major surgery) and that deaths result from the complication of appendicitis rather than appendicitis alone.

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## EXPERIENCES WITH ACUTE RHEUMATIC FEVER OVER A FIVE YEAR PERIOD

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Clarence Sullivan, B. S.

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Acute rheumatic fever is a most perplexing problem because its correct diagnosis is often very difficult. Children have been put to bed unnecessarily and others have continued with their active disease. In an effort to discover the instances and manifestations of rheumatic fever in Kentucky, a review of all cases admitted to the Louisville General Hospital and the Louisville Children's Hospital for the past five years was made. The outcome of that review is the basis of this report.

### Hospital Admittance

The General Hospital is a hospital that admits indigents of Louisville and Jefferson County. The Children's Hospital is a general pediatric hospital that admits children, both indigent and private, up to the age of 13 years from any place in the state. Total admissions for each hospital are given in Table I along with the total admissions for acute rheumatic fever, regardless of age, and the admissions to pediatrics for rheumatic fever. Included in this latter are readmissions as well as first admissions. The size of the problem is understood from Graph A and B which give the number and incidence respec-

tively of first admissions for rheumatic fever in the pediatric age group; particularly since it has been shown that most rheumatic fever begins in childhood<sup>1</sup>. These graphs do not include those that were seen in the Pediatric Out-Patient Clinic and treated on out-patient basis.

We do not have readily available a good explanation for the increased incidence in 1950, although we are cognizant of the fact that there are so-called good and bad years for rheumatic fever. Graph C is the total number of cases of rheumatic fever in the pediatric age group regardless of whether they were admitted for the first time or were readmissions. The number of deaths from this disease in the pediatric age group for these five years is 15, giving a mortality rate of 8.02 per cent. Interestingly enough, even though the number of cases of rheumatic fever admitted to the hospital increased in the year 1950, the total number of deaths fell from 6 in 1949 to 2 in 1950. We again have no good explanation for this drop in mortality. Lichtwitz<sup>1-b</sup> found the mortality rate to be 4 per cent with the first attack. Evaluation of the mortality from May Wilson<sup>1-a</sup> reveals that the mortality in the first year is 2 per cent, increases to 5 per cent by the fourth year, 10 per cent by the seventh year and 20 per cent by the eleventh year after the acute attack. She does not give any overall mortality from her experience. Hobbs<sup>2</sup> reported no deaths among 184 cases at Buckley Field.

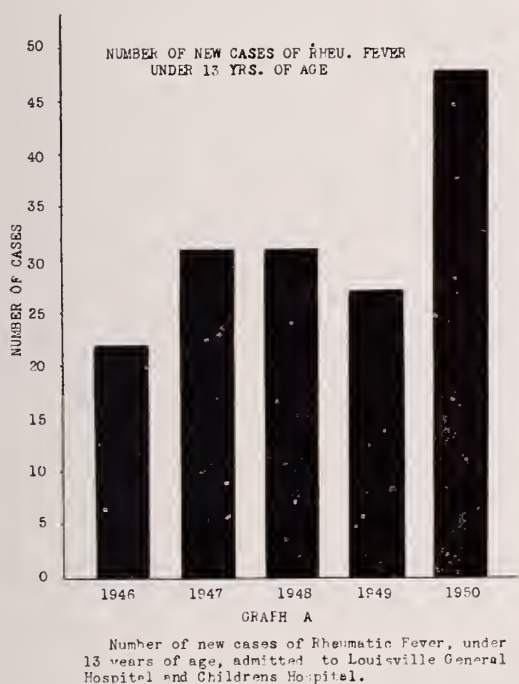
From the Department of Pediatrics, University of Louisville School of Medicine. This study was aided in part by a grant from the University of Louisville School of Medicine Aid for Student Research Scholars.

Read before the Sixth Councilor District, Bowling Green, May 7, 1951.

CHART NO. I

	1946		1947		1948		1949		1950		5 YR. TOTAL	
	CH	LGH	CH	LGH	CH	LGH	CH	LGH	CH	LGH	CH	LGH
TOTAL ADMISSIONS	1,333	11,129	1,603	8,368	1,452	8,863	1,153	9,325	1,425	10,047	7,471	48,232
ACUTE RHEUMATIC FEVER ADMISSIONS	13	18	23	20	24	19	18	20	25	34	103	111
PEDIATRIC ADMISSIONS FOR RHEU. FEVER	13	14	23	13	24	14	18	17	25	26	103	84

COMPARISON OF TOTAL ADMISSIONS, ADMISSIONS FOR ACUTE RHEUMATIC FEVER AND ADMISSIONS TO PEDIATRIC SERVICE FOR RHEU. FEVER



### Comparative Incidence of Hospital Admissions

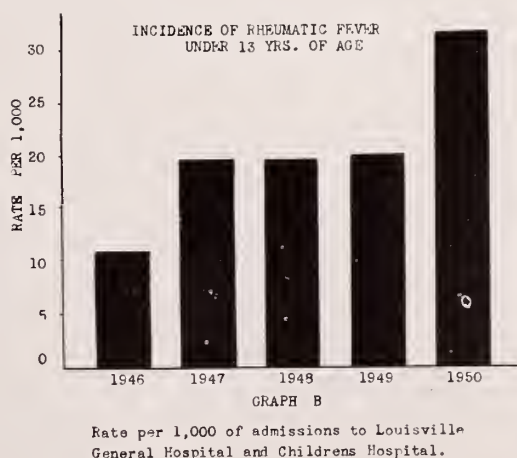
These figures reveal that .22 per cent of the total admissions to the two hospitals were for rheumatic fever in the pediatric age group over this five year period. Admissions to Children's Hospital for rheumatic fever were 1.38 per cent of the total admissions. This latter incidence of hospital admissions is comparable with that found by Nichol<sup>3</sup> for Boston, Massachusetts of 1.4 per cent. Longcope<sup>4</sup> found that the incidence of hospital admissions in Baltimore, Maryland (Johns Hopkins Hospital) was 1.3 per cent, and McLean<sup>5</sup> reported an incidence of hospital admissions of 1.8 per cent for Birmingham, Alabama. Wood and Hart<sup>6</sup> found that the

overall incidence of hospital admissions in Virginia was .48 per cent for the central section and .15 per cent for the eastern section.

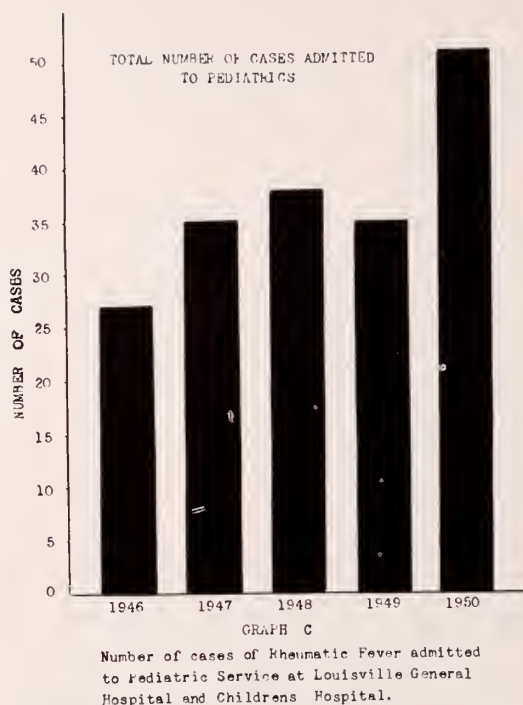
The general conclusions from this discussion of incidence and mortality rate reveal that our incidence of rheumatic fever is probably comparable with others in the United States, and our mortality rate seems somewhat high, but we have no good means of comparing our rate with those of others.

### Various Symptoms and Signs

Table II gives the incidence of various symptoms and signs found in the disease over this five year period. The importance of the evidence of carditis, migratory polyarthritides and elevation of the corrected erythrocytic sedimentation rate is easily seen. Better than 80 per cent of the patients admitted with acute rheumatic fever during this period showed one or more of these signs. Of those exhibiting cardiac murmurs, not a single case was found with aortic valve disease without







concomitant disease of the mitral valve. Fifty-eight and four-tenths per cent of the patients had mitral murmurs and 16.9 per cent had both mitral and aortic murmurs. Only four children during this five year period revealed E. K. G. changes that were diagnostic enough to indicate some myocardial disease that did not at the same time manifest some cardiac murmur. Elevation of leukocyte count above 10,000 per cubic millimeter was found in 63.4 per cent of the patients, and temperature of above 100 degrees was present in 54.7 per cent of the patients. Tachycardia above 100 per minute was present in 53.3 per cent, and was found to generally parallel that of fever. Lack of what would be termed fever in half of our patients and leukocytosis in approximately 40 per cent of the patients, revealed the unreliability of these two signs in the diagnosis of rheumatic fever.

A further breakdown of the patients exhibiting a leukocytosis above 10,000 white blood cells per cubic millimeter was made. This revealed a total of 101 patients. Of these 101 patients the great majority had a leukocytosis between 10,000 and 20,000 white blood cells per cubic millimeter. Only 13 of the patients had counts greater than 20,000.

A true anemia below 10 grams per cent hemoglobin was found in 15.7 per cent. Hematuria on the other hand was found in

28.3 per cent of the patients, and about 10 per cent of our patients exhibited chorea. A positive family history of rheumatic fever was found in 14.4 per cent of the total patients, but it is felt that this figure is probably lower than the true incidence because a specific family history was not obtained each time. If greater emphasis had been placed on the finding of positive family history of rheumatic fever we believe that this incidence would rise.

### Sex Distribution

The distribution of our patients over the five year period was approximately equal between males and females. No single finding was present in every case. None of our patients exhibited subcutaneous nodules at any time during the disease. The findings of this study which covers a five year period are relatively comparable to the findings of others, and reveal the protean nature of rheumatic fever. This review also sharply points out the unreliability of the present status of reporting to the State Health Department of acute cases of rheumatic fever. A review of the statistics<sup>7</sup> of the State revealed that only 18 cases of acute rheumatic fever were reported in 1949, 6 cases in 1948 and 1 case in 1947. The error is readily seen when these totals are compared with the totals from our hospitals. Interestingly enough in 1949 there were 23 reported

### CHART NO. II

#### NUMBER AND PERCENT OF SIGNS AND SYMPTOMS OBSERVED

	Number	Percent of Total
MALES .....	78	50
FAMILY HISTORY OF RHEU. F. ....	23	14.4
MIGRATORY POLYARTHRITIS ....	143	82.3
CARDITIS .....	137	86.1
MITRAL MURMUR ALONE .....	93	58.4
AORTIC AND MITRAL MURMUR ..	27	16.9
CHOREA .....	17	10.6
FEVER .....	87	54.7
TACHYCARDIA .....	84	53.3
ANEMIA .....	25	15.7
LEUCOCYTOSIS .....	101	63.4
HEMATURIA .....	45	28.3
ELEVATION OF SED. RATE .....	131	89.9
CHANGES IN E. K. G. ....	60	37.7

deaths due to acute rheumatic fever under the age of 19 years.

# Changes in Electrocardiograph

It is worthwhile to point out that in this group of patients we found 37.7 per cent that revealed changes in the electrocardiogram. The QT interval<sup>8</sup> was not measured on these electrocardiographs. However, our evaluation of the electrocardiograms was comparable to that of Levy and Turner, and Rotschild, Sacks and Libman<sup>9</sup>. It is slightly more than the 20 per cent incidence reported by May Wilson<sup>1-a</sup>, and much less than the 95 per cent incidence reported by Cohn and Swift<sup>10</sup>.

# Conclusion

1. The incidence of rheumatic fever for the State of Kentucky as exhibited by hospital admissions is given.

2. The relative incidence and number of selected symptoms and signs are given.

3. From the data observed it would seem of most importance to find evidence of migratory polyarthritis, carditis and elevation of the corrected erythrocytic sedimentation rate before making a diagnosis of rheumatic fever.

4. The aortic valve is not usually affected by the disease process until the mitral valve has been attacked.

5. The findings of this survey is compared with the findings of others.

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## *Special Articles*

### **SOME OBSERVATIONS ON THE MALARIA PICTURE IN KENTUCKY**

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The U. S. Public Health Service is becoming very concerned with the potential problem of malaria once more becoming endemic in the United States. Communications have been received suggesting that significant numbers of armed forces personnel from Korea are experiencing attacks of vivax malaria after their return to this country or while they are not under military supervision, i. e., while they are on furlough or after discharge. It is felt the appearance of these delayed malaria attacks are due to one of two reasons, either to a prolonged incubation period or to the effect of suppressive medication.

Statistics show that for the first six months of this year, 106 cases of malaria were reported from army camps in Kentucky. For the months of July and August, 335 cases were reported. These figures show the increasing gravity of the situation. In these cases malaria was contracted out-side the United States. For quite some time there have been no proven cases of malaria occurring in the civilian population. Recent spot surveys were attempted in the western part of the State, where malaria was at one time endemic, and up to this date all the smears have been negative. However, it should be borne in mind that the vector, *Anopheles quadrimaculatus*, is still indigenous throughout Kentucky. Since this is the case, the U. S. Public Health Service feels that all physicians should be warned to suspect malaria among patients who have been in Korea during the last year who present suggestive signs and symptoms. It is recommended that diagnosis be definite and based on demonstrations of malaria parasites in laboratories approved

by the State Health Department and not based merely on clinical signs and symptoms. In cases where the diagnosis is positive, controversial or uncertain, two slides should be sent to the State Health Department where they will be forwarded to the National Depository for malaria slides, in Georgia. There is no need to send slides which are believed to be negative. This central laboratory has three purposes: 1. to establish a depository for all malaria slides reported to be positive, 2. to provide expert diagnostic services to verify or question previous determinations, 3. to provide the best referee service by non-partisan, un-governmental consultants to decide whether or not parasites are present on controversial slides.

The Korean type of malaria, a temperate zone variety of *Plasmodium vivax*, has a characteristically long latent period during which delayed primary attacks may occur from two hundred fifty to three hundred days after infection, particularly if the individual was on suppressive therapy at the time of infection. Some of the cases receiving complete courses of modern anti-malarials will remain free from malaria, but it is probable that others will relapse after weeks or months. Patients should be told of this possibility and advised to seek medical treatment again as symptoms recur. The likelihood of clinical reaction becomes less with the passage of time and relapses are rare after the second or third attack.

Recommendations for treatment as submitted by the U. S. Public Health Service are as follows:

1. TREATMENT OF ACUTE ATTACKS OF MALARIA. Quinine, quinacrine, chloro-

quine (and analogous 4-aminoquinolines) and chlorguanide, when given in adequate dosage, will nearly always stop acute attacks of malaria. Choice of drug, therefore, depends upon such factors as rapidity of effect, incidence of side-actions, length of treatment period, incidence of falciparum relapses, latent periods before vivax relapses, natural or acquired strain-resistance, and the cost and availability of drug. Chloroquine is superior in most of these respects and is currently regarded as the drug of choice for routine therapy.

2. SUPPRESSION OF MALARIA. The aforementioned drugs, when given in properly spaced doses, will usually keep malaria latent under conditions of exposure in the field or following therapy of an acute attack. Choice of drug depends upon the incidence of break-throughs and of undesirable side-actions, the required frequency of dosage, and the persistence of protection if doses are missed, as well as upon cost and availability. Chloroquine in weekly dosage has proven to be a satisfactory suppressant, but further comparative trials are needed to determine the re-

lative merits of chloroquine, chlorguanide, and the less well known 4-aminoquinolines.

3. CURE OF VIVAX MALARIA. In relapsing vivax malaria, concurrent treatment with quinine and an 8-aminoquinoline, such as pamaquine, pentaquine, or isopentaquine, offers the best chance of radical cure. Pentaquine and isopentaquine afford greater margins of safety between effective and toxic dosages.

Competent diagnosis and adequate treatment are essential in the prevention of the spread of malaria. It is suggested that prompt reporting to local health authorities be put into effect so that arrangements can be made whereby residual insecticides may be applied to houses within a mile of parasite-positive persons. The report should indicate: 1, The type of malaria; 2, whether it be a primary attack; 3, whether the infection was acquired outside the United States; 4, whether the patient was in military service overseas and if so whether he was ever treated for malaria.

## KENTUCKY'S TUBERCULOSIS SANITORIA

**John B. Floyd, M. D.**

Chairman, State Tuberculosis Sanitoria Commission

RICHMOND

and

**William W. Richardson, M. D.**

Medical Director, District Three Sanatorium

PARIS

Now that the new State Tuberculosis Sanatoria are in operation, it is probably worthwhile to review the statewide situation and the facilities available. There are five new sanatoria with a capacity of 100 beds each and there is the original hospital, Hazelwood, located in Louisville, which can care for 250 patients. Listed in the order of their districts, they are: Madisonville, Louisville, Paris, Ashland, London and Glasgow. Four counties have their own sanatoria, in part state supported; Fayette, Jefferson, Kenton and Warren and together with the Veterans Administration Hospital at Outwood, add 1,113 beds, making a statewide total of 1,863 beds available. In 1950, 1,081 people

died of tuberculosis in Kentucky, more than the deaths due to all other communicable diseases combined. On the basis of 2 beds per annual death, our requirements would be 2,162 beds so that we are still a little below the optimum. It would, however, be possible to add 50 beds to each of the new State hospitals without additional construction. The 1950 death rate in our state was 36.6 per 100,000 population which represents a considerable improvement but still ranks us 47th in the 48 states.

### Admission Policies and Procedures

Application for admission to a State Sanatorium may be made by the physi-



cian in charge of the case or through the County Health Department to the Director of the regional Sanatorium. Blanks may be obtained from the Sanatorium and should be submitted together with a recent chest x-ray. Notification will be sent promptly as to whether the case can be accepted and when. Clinics are held regularly and patients may be referred to them for x-ray, physical examination, laboratory examinations and complete evaluation of their pulmonary status.

It is the policy of the State Tuberculosis Sanatoria Commission to reserve the beds for the patients whom treatment can most benefit. The hospitals would be of little use if they contained large numbers of chronic and hopeless individuals who would tend to exclude more favorable cases. However, in view of recent advances in treatment, many more people can be helped and the number refused is fortunately not large.

### Financing

The hospitals are designed to care for all the people of Kentucky. Home care is, of course, feasible under good circumstances and certain individuals may be able to pay for private hospitalization. However, the disease usually requires months of treatment which is a considerable drain on even the moderately well-to-do. By State Law, it is mandatory that 50% of the patients be cared for without charge. It is desirable and even essential that the others pay a part of the cost of their hospitalization. It is necessary that the hospitals collect at least 15% of their operating costs for the program to continue. Part of the revenue comes from the Clinics where, when possible, a reasonable charge is made.

### Treatment

Therapy in this disease was greatly improved with the introduction of Streptomycin, first readily available in 1947. The later addition of PAS (para-aminosalicylic acid), usually used in combination, was a further advance. With these drugs many formerly hopeless cases, especially those with acute fulminating disease, can now recover.

Thoracic surgery is also a field where considerable recent progress has been made. We are especially proud of the re-

sults at Hazelwood where a central surgical service for all the State Tuberculosis Hospitals has been established. Every facility for modern surgical treatment is available there and the overall morbidity and mortality rates compare very favorably with those achieved elsewhere. Pneumoperitoneum and pneumothorax are, of course, used in all our hospitals and any accepted form of treatment is available to our patients.

### Relations With The Medical Profession

We realize that the tuberculosis program in Kentucky can not be successful without the cooperation of the practicing physicians and surgeons of the State. We, in turn, wish to make the sanatoria as useful as possible to the profession. A prompt answer is sent to the physician and the County Health Department to any application received and every effort is made to admit all patients who can be benefited. Reports are sent as soon as possible on patients seen in the Clinic. On discharge, a case summary is mailed to the referring physician, with a copy to the County Health Department. The patient is referred back to his own doctor for further treatment but at the option of the physician, he may return to the hospital for out-patient treatments and check-ups and reports of these examinations, with recommendations, will be sent at once.

The physicians and surgeons throughout the State have been extremely co-operative in providing consultant advice and treatment for non-tuberculous conditions among our patients, in many cases without charge.

### Conclusion

This is a new program for Kentucky which will require the cooperation of organized medicine and of every individual physician to take advantage of the fine facilities, available for the first time, for treatment and control of pulmonary tuberculosis. The Medical Profession, the Health Department, The Tuberculosis Association and the State Sanatoria working together should be able to produce a sharp drop in the incidence and death rate of this most important of all communicable diseases.

# *The* JOURNAL *of the* Kentucky State Medical Association

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## A MEMORABLE CELEBRATION

After all, Centennial Celebrations occur only once in a hundred years and hence do not tire us with their repetition. Our State Association, in recognition of this fact, and in honor of the advances in medicine and the progress of our Association, planned and carried out a meeting that was excellent in every respect. All past records were shattered. Every phase of the meeting excelled over all previous meetings.

Meetings such as this do not happen by accident. Only those officers of the Association, members of the various committees, and members of the headquarters staff who participated in planning the meeting and attended to the multiplicity of details can fully appreciate the tremendous amount of effort that was required. President Sam A. Overstreet was the Planner-and-Worker-In-Chief and spent much of his time during the past two years in insuring an outstanding meeting. Because of their lack of knowledge concerning the contribution that he

made, the membership cannot fully recognize the magnitude of their indebtedness to him.

It was agreed that a record of this celebration should be preserved for medical posterity and the Journal staff has attempted in this issue to captivate by word and picture many of the most important events of the meeting. We felt that we would be remiss in our duty not to do so. It might well be that the Centennial Issue of the Journal, as well as this follow-up issue, will be prominently displayed at the Bi-Centennial Celebration in the year of 2051.

The Centennial Meeting placed a most elaborate period at the end of a chapter which was a hundred years in writing. The next chapter is as yet unwritten. We of today and our successors of tomorrow must meet the challenge of its blank pages by recording upon them unending progress in medical knowledge that will permit our profession to render an ever increasing service to the people.



## THE PROFESSION'S RESPONSIBILITY FOR MEDICAL LEGISLATION

Although there are still some physicians who think medicine and politics do not mix, happenings on Capitol Hill have brought others to the opinion that they can at least be emulsified. We agree that if politics were correctly defined as partisan skullduggery or if it means that personal integrity must be sacrificed, then it is beyond the pale. It is our opinion, however, that no person, be he physician or layman, is a good citizen who does not take part in true politics. One is not a good citizen who does not vote. One is not a good citizen who is not interested in good government.

Physicians, particularly Kentucky physicians, have the additional responsibility of providing leadership in all fields of health. One important phase of this responsibility is to see that all proposed legislation that pertains to medicine and is in the interest of the public is enacted into law, and, conversely, to defeat medical legislation that is not in the public interest.

In some states the Department of Health and the State Board of Health are political footballs and the profession is not able to protect either itself or the public from political interference in the field of health. The responsibility for leadership in health activities should be recognized by the profession as being in reality a privilege to be cherished. As is so often true, the price of privilege is duty. When the payment is not met, privilege is often repossessed. We think this is particularly true in regard to medical legislation. If leadership is not provided by the profession, it is inevitable that it will come from other sources with disastrous results for

the profession and for the people.

Why all this ado about the matter? It is due to the fact that an unusual number of bills concerning the practice of medicine and the public health will be introduced in the 1952 General Assembly. This legislation is extremely important. It is imperative that it have the support of the profession. The Medical Practice Act which was enacted in 1904 and is now obsolete and outmoded will be revised. Health laws which at present are inadequate will be codified and brought up-to-date. A hospital licensure law will again be introduced. All of these acts, and others that are under consideration, will have been carefully studied and approved by the Legislative Committee and the Council of the Kentucky State Medical Association and by the State Board of Health. They will be in the public interest. They will be in the interest of the profession. Complete information concerning them will be furnished to each County Medical Society. Whether or not they will become law will largely depend upon the support given them by individual physicians.

It is the duty and the privilege of every physician to discuss this legislation with his state senator and representative and to show them that the profession has no axe to grind but is acting in behalf of the people.

Representatives cannot truly represent a silent constituency, and when physicians provide unselfish leadership in medical legislation it will be welcomed and appreciated by their legislators. Only then will such legislation be given the serious consideration by the legislature that it merits.

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## BLUE SHIELD PLAN AGAIN INCREASES BENEFITS

Kentucky's Blue Shield Plan has again increased benefits to its subscribers without increasing premium rates. Indemnities have been upped considerably on numerous surgical procedures, in many instances as much as 50 per cent, and Medical Rider benefits have been increased 66 per cent, from an allowance of \$3.00 per day to \$5.00 per day. Medical Rider benefit payments begin on the fourth day of hospitalization and are made to physicians

for medical care of subscribers who are hospitalized for non-surgical illnesses. This change is particularly welcome since it permits the general practitioner and his patients to derive more benefits from the plan. This is as it should be since the success of the Plan depends upon the cooperation of general practitioners, and the Board of Directors was gratified to learn that experience to date indicates that it is possible to increase medical rider bene-

fits and remain actuarially sound. The complete list of the revised surgical indemnities is carried elsewhere in this issue of the Journal (see page 526).

Also revised were indemnities for multiple operations. Formerly when two or more operations were performed concurrently, or during the same period of hospitalization, only the indemnity for the procedure carrying the greater or greatest fee was paid with no allowance for the other procedures. As revised, if two or more surgical procedures are performed by the same physician concurrently or immediately successively, the fee for the two or more procedures will be the great-

er or greatest fee plus one-half each smaller fee or fees, not to exceed a maximum of one hundred and fifty dollars. Incidental appendectomies are excluded.

These revisions are important since they increase benefits and make the Plan more attractive to the subscriber. The success of the Blue Shield Plan is of so great importance to the medical profession, any added feature that will result in coverage of a larger portion of the population is most desirable.

The Board of Directors of Kentucky Physicians Mutual is to be congratulated for this, another major advance in the field of voluntary health insurance.

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## MEDICAL STUDENT INCREASE EQUIVALENT TO FIFTEEN NEW SCHOOLS

Medical education is now safely in the hands of competent and conscientious educators, and there are no unapproved medical schools in the United States. Nevertheless, the American Medical Association remains vigilant and through its Council on Medical Education encourages the training of a sufficient number of physicians to provide adequate medical care for the people without sacrificing hard won gains in quality of training.

In its fifty-first annual report, the Council depicts the present situation. The 1950 freshman class totaled 7,182 students, and this year's class is approximately 7,400. There are 26,191 medical students enrolled in the 79 schools this year, which exceeds last year's total by 1,000. This represents an increase of almost 5,000 over the 1940-41 enrollment, the last pre-war year. The Council estimated that this expansion in the capacity of the medical schools is equivalent to the establishment of fifteen new schools of average size. Graduating classes, too, are growing. This year 6,135 seniors were graduated. By 1953, the number of graduates is expected to exceed the peak of 6,389 which was reached in 1947, when, under the accelerated program, several schools graduated more than one class.

Competition for acceptance has been so keen for the past several years that few "C" students were admitted. Greater capacity of the medical schools and decrease of the backlog of veterans whose education was delayed by the war is changing

this situation. Twice as many "C" students, 20 percent, were accepted in 1950 as in 1949. Whether the acceptance of a greater number of students making lower grades in premedical courses will result in the graduation of less competent physicians remains to be seen. Even though the unusually large number of able students seeking admission to medical school has been reduced, the Council reports that there were slightly more than three applicants for each opening in last year's freshman class.

The report indicates that schools are still experiencing some difficulty in recruiting teachers. Progress is apparently being made, however, since fewer vacancies exist than were reported last year. As of June, 1951, the total number of vacant full-time positions was 235 as compared with 281 in 1950 and 441 in 1949. The Council pointed out that continuing to train an adequate teaching force is particularly important in view of the further expansion contemplated in existing schools and in order to meet the need for teachers in the several new medical schools that probably will be established within the next few years.

Reflected in the report is further evidence that medical schools are increasing their interest in training students to become family physicians and general practitioners. One or more courses designed to interest and prepare graduates for careers in general practice are being sponsored by fifty-four schools.

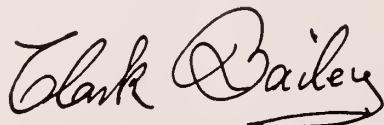


# *President's Page*

Our New Year has already begun. The seconds are ticking away without the loss of a single one. So many are already behind us. And yet our problems to be solved are just as great—some apparently more urgent. Just as the problems of our economy take on a different complexion, so the problems of our profession wear new costumes, sometimes creating in our minds unnecessary perplexity. The aims and ideals of our profession are constant and without variation, although the images registered on our minds may be distorted and blurred by ignorance, misrepresentation, prejudice, and indifference.

The medical profession in our state of Kentucky has enjoyed a most wonderful year. Under the leadership of Dr. Sam A. Overstreet a tremendous amount of work has been done by our members, splendid progress has been made, achievements too numerous to mention—all of them—have been accomplished.

Many tasks are ahead of us this coming year—tasks that must be done for the best interest of our profession. Yet, they cannot be successfully accomplished without the sincere cooperation of our members in a great spirit of unity for our noble profession. It is my desire as your president to acquaint you each month through this page of some of our more immediate problems and how we as a profession can work together toward solving them. Let us realize the necessity of following the motto of the great Commonwealth of Kentucky adopted in the year 1792, and that is truly applicable today to organized medicine in Kentucky, "United we stand, Divided we fall."

A handwritten signature in cursive script, reading "Clark Bailey". The signature is fluid and elegant, with a long horizontal flourish extending from the end of the name.

PRESIDENT

# ORGANIZATION SECTION

## Dr. Bauer To Address County Society Officers Conference, Feb. 7

Louis H. Bauer, M. D., Hempstead, New York, President-Elect of the A.M.A. and Secretary of the World Medical Association, will be one of the featured speakers at the Second Annual County Society Officers Conference to be held Thursday, February 7, 1952.

The day-long session, which is under the supervision of the Council, will be staged in Louisville at the Brown Hotel. Dr. Bauer who has been described as "an astute medical statesman and a gifted speaker" will give the luncheon address.

Current problems faced by county medical society leaders will be discussed by nationally known speakers who are specialists in their particular field. The morning and afternoon discussion periods, when these speakers may be questioned, will provide our county officials with the opportunity of getting topflight advice.

This conference is the only meeting of its kind and is held once a year for the sole benefit of the local medical society officials. More than 100 attended the first conference early this year. The initial meeting has been termed both profitable and popular with the county leaders.

## Telephone P. G. Courses To Be Held In February, March and April

Plans for the Telephone Postgraduate Course, that is being sponsored by the Kentucky State Medical Association in cooperation with the University of Louisville School of Medicine, and which will be staged during February, March and April of 1952, are rapidly nearing completion.

The Committee on Medical Education of the Association is in charge of this new K.S.M.A. program which is designed to bring the latest and best in postgraduate instruction to the small county medical societies in the state who would otherwise be denied these advantages, Robert Lich, M. D., Louisville, new 1951-52 Chairman of the Committee, said.

A full outline along with a generous number of illustrations and diagrams in the form of a manual for each evening's program, will be sent each member of the county societies taking part about ten days before the course

starts, Herbert L. Clay, M. D., Director of Postgraduate Refresher Training at the University who will be in charge of the program, stated. Members will be encouraged to carefully review material and submit questions that may arise. These questions will be answered near the close of the broadcast.

Live broadcasts of this nature are new to Kentucky physicians, but have been worked on a state and national basis most successfully, Dr. Lich explained. The programs will emanate at the Louisville General Hospital and will be transmitted by special wire to the "mixer" at the central telephone office. From there the program will be piped out to subscribing county societies' meeting rooms.

The average cost to each member of participating county societies will be about fifty cents plus having a loud speaker set up in the usual meeting place of the society. Local telephone officials will cooperate in arranging for amplification.

Other members of the new Committee on Medical Education are D. G. Miller, Jr., M. D., Morgantown; Lawrence T. Minish, M. D., Louisville; J. R. Gott, M. D., Louisville; and Herbert L. Clay, Jr., M. D., Louisville.

## Committee Urges Hospitals To Send Intern-Resident Data

All hospitals in Kentucky are urged to complete Selective Service Form No. ODM-101, giving full information on physicians in their intern and resident services, and to send it in as soon as possible, A. Clayton McCarty, Louisville, Chairman of the Kentucky State Advisory Committee to Selective Service, said.

The Selective Service forms were sent to the hospitals early this fall with the request they be filled out and returned. The purpose of the forms is to provide Selective Service with adequate information on which it may base its calls—and at the same time not hamper essential services at the hospital.

Pointing out to intern committees and officials of the hospitals the importance of cooperating in this matter, Dr. McCarty warned that the State Advisory Committee could not be expected to keep the proper balance between physicians working in hospitals and the armed forces if the committee was not properly informed.



## THE CENTENNIAL IN RETROSPECT

### Delegates Raise Dues and Provide For Negro M. D. Membership

Raising the membership dues from \$15.00 to \$25.00 a year and changing the By-Laws to provide for the membership of Negro physicians in the K.S.M.A. highlighted the House of Delegates action at the Centennial Meeting.

Disposing of a heavy agenda in record time, the delegates authorized an increase in dues to meet the rising costs incident to publication of the Journal and maintenance of the services of the Association at the present level.

The House altered the By-Laws to admit Negro physicians as members in either of two ways. First, to provide for colored membership through the local county medical society of those counties that want to admit them. Second, to authorize the chartering of a state wide colored component society, with members of the new component group being eligible for K.S.M.A. membership.

Officials of the Association expressed themselves as being pleased with the operation of the Reference Committee system, which was employed for the third successive year. Advantages of the system are that it greatly expedites the business of the house, at the same time retaining true democratic parliamentary procedures.

Attendance of delegates was unusually good with 67 per cent or 94 out of an eligible 140 being present. The average state delegate at-

tendance is 60 per cent of the total eligible. Of the 24 officers of the Association eligible to attend, 24 attended the first meeting and 22 the second.

### Dr. Sparks Named Chairman of Council And Executive Committee

Clyde Sparks, M. D., Ashland, Councilor for the Thirteenth District, was elected Chairman of the Council at the organization luncheon meeting of the new Council, October 4, during the Centennial Session.

The evening before, the House of Delegates had altered the By-Laws to provide for a new Executive Committee of the Council. Under the new set-up the chairman of the Council will be the chairman of the Executive Committee. The committee will be made up of the Chairman, the President of the Association, Clark Bailey, M. D., Harlan, and two Councilors, with the Executive Assistant serving as Secretary to the Committee.

In addition to Chairman Sparks, the two Councilors elected to the committee are B. B. Baughman, M. D., Frankfort, and R. R. Slucher, M. D., Buechel. The Executive Committee was activated for the purpose of relieving the Council of the increasingly heavy load it has been called on to bear as a result of the growth of the Association.

Dr. Sparks, the new chairman of both the Council and Executive Committee, succeeds C. C. Howard, M. D., Glasgow.



Members of the House of Delegates at the first meeting peruse the numerous reports found in their envelopes. A heavy agenda was disposed of in the well-attended sessions.



Left to right: Speaker Hugh L. Houston, M. D., Murray, calls the first session of the House to order. Center, Bruce Underwood, M. D., Louisville, reads his Secretary's report. Right, George F. Lull, M. D., Sec. and General Manager of the A.M.A., spoke briefly at the close of the first session.



The exhibit hall, displaying the scientific exhibits and the booths of the technical exhibitors, was a crowded, popular, colorful place throughout the Centennial. The above, taken soon after the opening of the hall, shows a portion of the 510 linial wall feet of scientific exhibits on the second floor. Below are shown a part of the 64 technical exhibits.





Clark Bailey, M. D., Harlan, 1951-52 president, left, and Centennial President Sam A. Overstreet, M. D., Louisville, center, hold a pow-wow with President-elect R. Haynes Barr, M. D., of Owensboro, after his election at the second meeting of the House.

### Dr. Barr Named Pres.-Elect As New Officers Are Chosen

R. Haynes Barr, M. D., Owensboro, who, as Chairman of the Education Sub-Committee, has led the fight of Kentucky physicians against socialized medicine, was elected without opposition as President-Elect at the second meeting of the House of Delegates during the Centennial Meeting.

Dr. Barr, an active supporter of organized medicine, has served the Second District as Councilor since 1949. He will be installed as the 102nd president of the Association at the 1952 Annual Session. He is currently serving as president of the Owensboro Chamber of Commerce.

Vice Presidents selected by the House for the 1951-52 year are: Central Kentucky—Thomas V. Gudex, M. D., Louisville; Eastern Kentucky—Keith Smith, M. D., Corbin; and Western Kentucky—R. Ward Bushart, M. D., Fulton.

Beginning with 1952 K.S.M.A. will be eligible for just two delegates to the American Medical Association, as a result of the change in A.M.A. membership procedures. Kentucky has been eligible for three delegates since January, 1950. Bruce Underwood, M. D., Louisville, the Secretary and General Manager, was

chosen to succeed J. B. Lukins, M. D., Louisville, for a two year term, expiring December 31, 1953. J. Duffy Hancock, M. D., Louisville, was elected in 1950 to serve until December 31, 1952.

The practice of electing alternate delegates to the A.M. A. was initiated at the Centennial session of the House. W. Vinson Pierce, M. D., Lexington, was elected as Dr. Underwood's alternate. His term will expire December 31, 1953. C. C. Howard, M. D., Glasgow, was named the alternate for Dr. Hancock, with his term expiring December 31, 1952. Henry B. Asman, M. D., Louisville, was elected as Dr. Lukin's alternate and will serve until December 31, 1951.

Gaithel L. Simpson, M. D., Greenville, was selected by the House as the Orator in Surgery in 1952 and Joe M. Bush, M. D., Mt. Sterling, will be the Orator in Medicine.

The election of Dr. Barr as President-Elect created a vacancy in the Second Councilor District, and Walter L. O'Nan, M. D., Henderson, was chosen to fill out the unexpired term of Dr. Barr as Councilor.

Dr. Howard, who has been Councilor of the Sixth District for many years and who has currently been serving as Chairman of the

# **Auxiliary Pageant Wins Universal Acclaim at Centennial**

A historical pageant, featuring pictures depicting the various developments in the background and life of Ephraim McDowell, and staged Tuesday evening during the Centennial celebration at the Public Meeting in the Columbia Auditorium, was widely acclaimed.

The program was sponsored by the Woman's Auxiliary to the Kentucky State Medical Association and was under the general direction of Mrs. Clark Bailey, Harlan, 1950-51 State President of the Auxiliary, who was responsible for the program. Mrs. Ray Rice, Harlan, Mrs. Bailey's sister, directed the production and did the reading during the pageant.

One high official of the Association was heard to make the following statement to Mrs. Bailey and part of the cast after the show, which seemed to sum up what the audience of some 900 people thought of the tableaux: "Your program was beautifully done. The way it was developed, the selection and rendition of the music by the two very splendid musicians and the beauty and artistry of the living pictures was perfect."

Sharing the spotlight with the Auxiliary program was a former Kentuckian and native of Leitchfield, Lewis J. Moorman, M. D., of Oklahoma City. Dr. Moorman gave an excellent



Featured speaker of the Public Meeting was Lewis J. Moorman, M. D., native of Leitchfield, now editor of the Oklahoma Medical Journal. His subject was, "Kentucky, the Progenitor of Pioneer Doctors."

presentation of "Kentucky, the Progenitor of Pioneer Doctors." Dr. Moorman's paper will appear in the Centennial Volume, now on sale in the Headquarters Office.

Another highlight of the session was the memorial service so impressively conducted by Gant Gaither, M. D., Hopkinsville, for the 73 physicians who had passed away during the 1950-51 year.



Above are scenes from "Living Pictures," a tableau of the life of Ephraim McDowell presented at the Public Meeting during the Centennial by the Woman's Auxiliary. The different scenes depicted the life of the Kentucky surgeon from infancy to the time of the performance of the famous operation. A tribute to the doctors of today was read at the end.





Carl Norfleet, M. D., Somerset, right, accepts the distinguished service award from Bruce Underwood, M. D., Secretary and General Manager.

#### Awards Given Doctors Norfleet, Lukins and Kincheloe

Carl Norfleet, M. D., Somerset, J. B. Lukins, M. D., Louisville, and John E. Kincheloe, M. D., Hardinsburg, were chosen by the House of Delegates to be the recipients of the Association's three Annual Awards, which were presented at the Annual Public Meeting, Tuesday evening, October 2, Columbia Auditorium.

Dr. Norfleet was selected to receive the Distinguished Service Award, which was pre-



J. B. Lukins, M. D., Louisville, left, is presented with the E. M. Howard award by its donor, E. M. Howard, M. D., Harlan.

sented by Bruce Underwood, M. D., Secretary and General Manager, in behalf of the Association. Born in Pulaski County in 1881, Dr. Norfleet graduated from Hospital College of Medicine, Louisville, in 1905 and began his practice in Silversville. In 1908 he located in

Somerset where he practiced until 1917, when he entered World War I as a captain in the Army Medical Corps. In 1929, he became surgeon and general manager of the Somerset General Hospital, a job he held 12 years.

The director of the Pulaski County Health Department, Dr. Norfleet has been a member of the County Board of Health for over 40 years. Since 1946 he has been chief of staff of the new Somerset City Hospital. He has served the Association as Councilor of the Seventh and the new Twelfth District, as a Delegate to the House, and has been a member of the Medical Economics Committee for more than 10 years.

Dr. Lukins was voted the E. M. Howard Award for outstanding service in behalf of



John E. Kincheloe, M. D., Hardinsburg, won the J. Watts Stovall award as the outstanding General Practitioner of the year. Dr. Kincheloe was ill and not able to be present. His son, John A. Kincheloe, M. D., accepted it for him.

organized medicine, which was presented to him by E. M. Howard, Jr., Harlan. A native of Mt. Carmel, Fleming County, he was graduated from the Hospital College of Medicine in 1906 and began practice the same year. He has been a member of the surgical staff of Norton Memorial Infirmary, Louisville, 41 years, and, for 40 years, until 1950, he was Associate Professor of Gynecology at the Medical School.

One of the Association's most valued members, Dr. Lukins has been a delegate to the American Medical Association since 1941 and

is a member of the A. M. A. Judicial Council. He was President of the Association in the 1935-36 year, and has been Chairman of the Medico-Legal Committee for 27 years.

Dr. Kincheloe, a former winner of the E. M. Howard Award, received the J. Watts Stovall General Practitioner Award. The award, presented by J. Watts Stovall, M. D., Grayson, was accepted for him by his son, John A. Kincheloe, M. D., as Dr. Kincheloe was ill and could not attend. Born in 1877, Dr. Kincheloe has practiced at his native Hardinsburg since 1899, when he was graduated from the Kentucky School of Medicine.

He was honored at Hardinsburg in 1946 with a "Dr. Kincheloe Day" attended by some 5,000 persons—including many of the 5,496 he had brought into the world.



Another high point in the Centennial meeting was the President's luncheon, Wednesday. In a portion of the overflow crowd shown above, President Sam A. Overstreet is at the podium and John W. Cline, M. D., San Francisco, President of the A.M.A., is at his left.

### AMA Chief Discusses Medical Issues At President's Luncheon

John W. Cline, M. D., San Francisco, President of the American Medical Association, was the principal speaker at the President's Luncheon of the K.S.M.A. Centennial Meeting, which was held October 3 in the Brown Hotel Roof Garden and attended by 232 physicians and guests.

Dr. Cline, who spoke on the subject "Medical Problems in the Immediate Future," told Association members that the A.M.A.'s campaign against socialized medicine had had the result of crystallizing more and more American public opinion against any form of socialized medicine.

"We must continue our campaign against socialism," he said. "I would estimate the bout



At the close of President Cline's address, S. C. Barnes, Elizabethtown, President of the Kentucky Chamber of Commerce, left, presents Dr. Cline with the "Key to My Old Kentucky Home."

is about half won. If every doctor had done the job he should have done, I think it could be over at the present time."

"We must improve public relations at all levels," he asserted. "The influence of doctors can be great if they will use it."

He urged doctors to support the A.M.A.'s efforts to give financial help to medical schools. This is the doctor's answer to government subsidization and resulting controls, he said.

He declared that the greatest bulwark against socialized medicine is the extension of voluntary-health-insurance coverage. Half of all Americans are covered by such plans, he said, and the A.M.A.'s goal is to have 80,000,000 Americans under such plans.



Living past presidents were introduced at the President's luncheon. Oldest living past president, D. M. Griffith, M. D., Owensboro, who served in 1906-07, listens to a tribute from youngest past president, Hugh L. Houston, M. D., Murray, who served in 1949-50.





The Centennial Banquet was the last feature of the 100th birthday celebration. 1. Clark Bailey, M. D., left, takes the oath of office to become the 101st president of the Association from Toastmaster J. Murray Kinsman, M. D. 2. Centennial President Sam A. Overstreet delivers his address entitled "Golden Spikes." 3. A portion of the special table of men who had been in practice for 50 years or more. 4. Class of 1901 of U. of L. Medical School was one of five who held reunions and had special tables.

## President's Address, Heard By 708 Features Centennial Banquet

Explaining the broad aims of the K.S.M.A. program for the expansion of medical education in Kentucky, Sam A. Overstreet, M. D., Louisville, retiring President, brought to a close the one-hundredth birthday celebration of the Association at the Centennial Banquet on an impressive note.

"Golden Spikes" was the title of the President's Address that was delivered to an overflow audience of 708 people in the Crystal Ballroom of the Brown Hotel, Thursday evening, October 4.

Dr. Overstreet described the thoroughness that had characterized the research into the problem. He paid high tribute to the members of the Council of the Association for their unselfish efforts. He paid high tribute to the members of the Council of the Association, who attended two special all-day sessions as the issue was carefully considered, for their unselfish efforts.

The program ended with the colorful inaugural ceremony, in which Clark Bailey, M. D., Harlan, took the oath of office, administered by Toastmaster J. Murray Kinsman, M. D., Dean of the University of Louisville School of Medicine, and was thus installed as the 101st President of the Kentucky State Medical Association.

Special tables were reserved for the University of Louisville reunion classes of 1901, '11, '21, '31 and '41, which were recognized and introduced to the gathering by Dr. Kinsman. Doctors who had practiced medicine fifty years or more were recognized and introduced individually.

Following the program, the Ballroom was cleared of the banquet tables and dancing concluded the evening's entertainment.

## Lexington Physician Wins Centennial Golf Tournament Honors

Marion G. Brown, M. D., Lexington, won top honors in the K.S.M.A. Centennial Golf Tournament, that was played at the Louisville Country Club, October 2, 3 and 4, during the 100th birthday celebration.

The winners of the prizes were announced at the Centennial Banquet by William C. Wolfe, M. D., Louisville, Chairman of the Centennial Golf Committee.

Other tournament winners were Paul B. Hall, M. D., Paintsville; Warren E. Sloan, M. D., Paducah; Vinson Pierce, M. D., Covington; and Thomas J. Overstreet, M. D., Lexington.



Brigadier Alvena H. Wood, Booth Hospital, Covington, President of the Kentucky Hospital Association, presented a \$1,000 check to the K.S.M.A. on behalf of her association, which was accepted by Sam A. Overstreet, M. D., retiring President, at the Centennial Banquet, Brown Hotel, October 4. Brigadier Wood asked that the money be used for the furtherance of medical education in Kentucky. The check will be turned over to the K.S.M.A. Scholarship Fund.

## Mrs. Harter to Lead Auxiliary, Mrs. Barrow Is Pres.-Elect

Mrs. John Harter, Louisville, was installed as President of the Woman's Auxiliary to the K.S.M.A. at its Annual Meeting during the Centennial Celebration, October 2, 3 and 4.

Mrs. Clark Bailey, Harlan, the retiring president, is the wife of the newly installed 101st President of K.S.M.A.

Mrs. David Woolfolk Barrow, Lexington, was chosen President-Elect at the session, attended by 234 members.

Mrs. E. W. Jackson, Paducah, was appointed editor of the quarterly publication, "The Blue Grass News." Mrs. Sam Flowers, Middlesboro, is the retiring editor.

## Order Your Centennial Volume Now

There is still time to order your Centennial Volume, which will contain all papers given at the Scientific Session at the Auditorium during the Centennial, together with a picture and biographical sketch of each essayist. It will also have the President's Address, pictures of all past K.S.M.A. presidents, a historical sketch of the Association and Ephraim McDowell, along with the A.M.A. President's address.

Send your order for this attractively bound memento, which costs \$5.00, to your county society secretary or the Headquarters Office.





Among the top attractions at the Centennial was the K. S. M. A. historical exhibit, presented by the Woman's Auxiliary. A series of 12 beautifully mounted, oil paintings, depicting 100 years of medical progress, were artistically displayed in shadow boxes at Columbia Auditorium. The three members of the Auxilliary's Committee who arranged for the exhibit were:

### Centennial Press, Radio and T-V Publicity Is Broadcast

Veteran observers declared that the publicity given the Centennial Meeting of the Association by the press, radio and television stations was very generous and the best in the history of the Association.

Before the meeting all weekly and daily newspapers in the state received news releases from the Headquarters Office, and the Louisville dailies carried stories and pictures on three different occasions prior to the Centennial.

During the meeting the Louisville Courier-Journal printed 130 column inches of news and the Times 53. Twenty-four pictures dealing with participants were carried. The Courier-Journal carried 12 column inches on the Woman's Auxiliary activities and 3 half tones.

Eight visiting essayists and four local physicians appeared on Louisville radio or television stations during the 100th birthday celebration.

Following the meeting news releases on new K.S.M.A. officers went to all state newspapers.

### Chest Physicians Hear Dr. Johnson At Luncheon Meeting

A luncheon meeting was held by the Kentucky Chapter, American College of Chest Physicians in the Brown Hotel, October 4, during the K.S.M.A. Centennial.

Julian Johnson, M. D., Philadelphia, Professor of Surgery, University of Pennsylvania Medical School, spoke to the gathering on "Philosophy of Chest Tumors."

Chest surgery has now progressed so far, Dr. Johnson said, that exploratory opening of the chest in suspected and unproven diseases carries no more risk than an appendicitis operation.

After the address a business meeting was held and the following officers elected:

Hugh L. Houston, M. D., Murray, President; E. R. Gernert, M. D., Louisville, Vice-President; Lawrence A. Taugher, M. D., Louisville, Secretary-Treasurer.

R. O. Joplin, M. D., retiring president, presided at the meeting, which was attended by about 30 physicians.



Reference Committee No. 3 considers reports of the Special Committees at its Tuesday afternoon meeting. Walter O'Nan, M. D., Henderson, extreme left, served as Chairman of the Committee.

### New Officers Chosen

Continued From Page 514

Council, eliminated himself as a candidate to succeed himself and was succeeded by L. O. Toomey, M. D., Bowling Green.

Edward B. Mersch, M. D., Covington, was named to succeed himself as Councilor for the Eighth District.

Charles Cawood, M. D., Middlesboro, resigned as the Councilor for the 15th District, and Edward Wilson, M. D., Pineville, was elected to fill out the unexpired term.



Mrs. Walker Owen, Mt. Vernon, (opposite page) who painted one of the pictures, Mrs. Irving G. Gail, Lexington, (above, right) who painted seven, and Mrs. Malcolm Barnes, Louisville, Chairman of the Committee. The permanent home for the historical exhibit is the museum of the Kentucky Building on the campus of Western College, Bowling Green.

### Therapy Seminar, Attended By 100 Is Final Centennial Feature

More than 100 physicians attended the Seminar on Therapy of the University of Louisville School of Medicine, Friday, October 5, at the Louisville General Hospital amphitheatre.

This day-long session was part of the four-day scientific program of the K.S.M.A. Centennial celebration, in which the University of Louisville School of Medicine cooperated.

The program was under the direction of Herbert L. Clay, M. D., Director of Postgraduate Refresher Training at the Medical School. Five hours credit were received by members of the Kentucky Academy of General Practice attending the Seminar, Dr. Clay said.

### Recording of Cline Talk Available

County medical societies, civic clubs and other groups may secure a complete recording of the 40 minute address by John W. Cline, M. D., American Medical Association president, given during the Centennial at the President's Luncheon. If you want your organization to hear this splendid talk, write the Headquarters Office of the Association now, giving complete information.

### Dr. Witherspoon's Name Omitted

The name of Ezra O. Witherspoon, M. D., Louisville, was not read when the graduates of the University of Louisville attending the Class of '01 Reunion were asked to stand at the Centennial Banquet in the Brown Hotel the evening of October 4. Dr. Witherspoon was present. The omission of his name from the list is sincerely regretted.

### Dr. McCahan of the AMA Addresses Industrial Physicians

The Committee on Industrial Medicine and Surgery of K.S.M.A. held a luncheon at the Brown Hotel, October 2, during the Centennial Meeting.

J. F. McCahan, M. D., of the Council of Industrial Health, American Medical Association, addressed the meeting. He called the field of industrial health a new frontier in medicine, and listed 4 activities which are vital for improvement in that field:

- (1) creation of public interest and demand
- (2) a clear statement of industrial health objectives
- (3) improved professional standards and training
- (4) better medical organization for industrial health on the part of both industrial physicians and medical societies

Gradie R. Rowntree, M. D., chairman of the section on industrial medicine and surgery, presided over the meeting. About 50 industrial physicians and traumatic surgeons were present.



Reference Committee No. 4, with George William Pedigo, M. D., Louisville, Chairman, seated at right, passed on the reports of the Advisory Committees.





Old friends meet as C. C. Howard, M. D., Glasgow, extreme right, retiring Chairman of the Council, visits with Woodruff J. Flowers, M.D., Columbia, at the Registration cage, one of the busiest places at Columbia Auditorium during the Centennial Meeting.

### Centennial Breaks All Registration Records As 1911 Attend

All attendance records for K.S.M.A. Annual Meetings fell by the wayside when a total of 1911 registered for the 100th Birthday Celebration in Louisville, October 2, 3 and 4, at Columbia Auditorium.

An impressive 45 per cent of all K.S.M.A. members, or 846, attended the session. In addition 138 guest physicians registered, along with 101 interns and residents.

Indicative of the growing interest of medical students in organized medicine was the registration of 330 medical students. A total of 375 are enrolled at the University of Louisville Medical School.

The official attendance totals by classifications are listed below:

Members .....	846
Guest Physicians .....	138
Guests .....	189
Medical Students .....	330
Registered Nurses .....	27
Interns - Residents .....	101
Technicians - Office Assistants....	76
Exhibitors .....	204

Total .....1,911

The Federal Aid to Medical Education bill has been returned by the Senate to the Senate Labor and Public Welfare Committee, and it is unlikely that the committee will reconsider the bill at this session of Congress, reports the Washington office of the A.M.A.

### Notice to County Society Secretaries

Materials designed to aid and assist the County Medical Secretary in reporting his 1952 membership, officers and delegates to the State Association is now being prepared, and will be sent out by the Headquarters Office by the end of the month.

In order that your 1952 County Medical Society officers may receive the particulars on, and plan to attend, the Second Annual County Society Officers Conference, February 7, a prompt reporting of your new officers, public relations and legislative committees is urged.

### Mason County Sponsors Atomic Course

The Mason County Medical Society sponsored a three hour course on treatment of atomic illnesses to which physicians in adjoining counties were invited, held at the Presbyterian Church in Maysville, Tuesday, November 9.

The course was organized by the committee on Emergency Medical Service of the K.S.M.A. in cooperation with State Civilian Defense organizations.

William H. Bizot, M. D., Louisville, took the surgical hour and Maurice R. Walsh, M. D., Covington, was the radiologist. An hour long film concluded the program.

### Muldraugh Hill Meets in Louisville

The Muldraugh Hill Medical Society will hold a meeting Thursday, December 13, 1951, at St. Anthony's Hospital, Louisville, and will present the following program:

10:00 A.M.

Case Reports

Fads and Fancies Concerning Rabies

L. H. South, M. D., Louisville

The Lure and Value of Medical History

Emmet F. Horine, M. D., Louisville

Sub Acute Bacterial Endocarditis

James Winter, M. D., Louisville

12:00 Noon

Luncheon, St. Anthony's Hospital

1:30 P. M.

Ophthalmoscopy in General Practice

George H. Ray, M. D., Louisville

Diagnosis and Treatment of Iron Deficiency Anemia

Captain Walter G. Coker, Ft. Knox

Urinary Tract Infection

Colonel Ralph Artman, Ft. Knox

Charles F. Long, M. D., Elizabethtown, is president of the society, and Joseph C. Ray, M. D., Louisville, is secretary.

### State Academy of G. P. Plans Post Graduate Instruction

Postgraduate education was the chief topic of discussion at the Board of Directors Meeting of the Kentucky Chapter of the Academy of General Practice, held Monday evening, October 1, during the Centennial Celebration.

"The Board feels," J. A. Bishop, M. D., Jeffersonton, one of the directors, said, "that postgraduate instruction to the practicing physician is one of the greatest benefits of the Academy to both the physician and the patient in that it brings not only better medical care to the patient but actually keeps the physician interested and alive to medical progress."

The directors' meeting was followed by a dinner, attended by members of the Academy and their wives. Officers of the Kentucky Academy of General Practice are: Richard R. Slucher, M. D., Buechel, President; Keith P. Smith, M. D., Corbin, Vice-President; and David G. Miller, Jr., Morgantown, Secretary.

### Priority I Induction Again Postponed

The induction of 485 Priority I medical officers, who were originally scheduled for induction in August and September, has again been postponed for the months of October and November, the Department of Defense announced October 5.

A sustained rate of volunteers has made possible this delay in calling the medical officers, of whom 333 were scheduled for induction in August and 152 in September, and it does not mean that requirements for medical officers have been reduced.

If the volunteer rate is not sufficient in the future to meet requirements, it will be necessary to make up the shortage by induction, the Defense Department said.

**Thomas Stigall, M. D.**, has opened an office at 2141 Dixie Highway, Louisville. He is a graduate of the University of Louisville School of Medicine in 1946 and interned at Louisville General Hospital. Before entering practice he was at Nichols Veterans Administration Hospital, Louisville.

**Charles B. Stacy, M. D.**, a member of the staff of the Pineville Community Hospital and a physician and surgeon of that area for the past 25 years, has been made a member of the International College of Surgeons. He was inducted into the society at the annual meeting of the organization in Chicago, September 13.

### Sixth Meets At Bowling Green

The Sixth Councilor District was scheduled to have a full program for its final meeting of the year at Bowling Green on Tuesday, November 13th, at the Helm Hotel.

The District was to meet its new Councilor, Lawrence O. Toomey, M. D., elect new district officers and hear a scientific program given by a surgeon and a radiologist from Louisville.

"Malignancies of the Oral Cavity" was the subject of the paper given by James C. Drye, M. D., and Alfred O. Miller, M. D., discussed "Antral Gastritis."

John W. Meredith, M. D., Scottsville, has been serving as President and William O. Carson, M. D., Bowling Green, as Secretary of the Sixth District. The retiring Councilor is C. C. Howard, M. D., Glasgow.

**The Pennsylvania State Medical Society** has pledged to raise \$250,000 by voluntary subscriptions of \$25 or more for the A.M.A. medical education fund, according to George F. Lull, M. D., A.M.A. Secretary and General Manager.

**John Wilson, M. D.**, director of the Ashland-Boyd County Health Department, resigned in August to enter general practice in Ashland. A native of England, Dr. Wilson came to Kentucky in 1945 after 15 years of practice in Birmingham, England. He was appointed director of health in 1949.

**Samuel C. Smith, M. D.**, became the new director of the Ashland-Boyd County Health Department on September 1, 1951. Dr. Smith has practiced in Ashland since 1921. He is a graduate of the University of Louisville Medical Department in 1912. Dr. Smith served his district as Councilor for many years.

**The Navy announced October 4 that it would** make 176 Naval hospital internships available to medical school students graduating in 1952, according to a release from the Department of Defense. Prospective interns must meet all requirements for a commission in the Medical Corps, U. S. Naval Reserve, and must serve a minimum of 24 months of active duty from the date they start intern training. Deadline for submission of applications is January 7, 1952.



## County Society Reports

### JEFFERSON

The 452nd meeting of the Jefferson County Medical Society was held Monday evening, September 17, 1951, at the Seelbach Hotel. Ninety-four members and guests were present for dinner.

The meeting was called to order at 8:05 P.M., by the President, Lytle Atherton, M. D.

The minutes of the last meeting were read and approved.

Newly elected members were recognized.

Foster D. Coleman, M. D., Chairman, Necrology Committee, read Resolution on the death of Oscar E. Bloch, Sr., M. D., and announced that copies of Resolutions on the deaths of William J. Coyle, M. D., A. L. Bass, M. D., J. Oliver Knight, M. D., and J. B. Shacklette, M. D., would be spread upon the minutes and sent to families of the deceased.

Alice Wakefield, M. D., Chairman, Professional Service Committee, read report of the committee regarding the need of making permanent plans for the continuance of the Physicians Exchange.

Motion by Louis Foltz, M. D., that the report be accepted as read and referred to the Executive Committee for study and recommendations at next meeting, seconded and carried.

Joseph Bell, M. D., Chairman, Executive Committee, reported action taken by the committee in taking space in the Centennial edition of the Courier-Journal for September 23, at a cost of approximately \$345.00, to the society.

Dr. Louis Foltz, Chairman, Public Relations Committee, showed a proof of the ad selected by the committee, to be dedicated to the Jefferson County Medical Society.

Charles Wood, M. D., Chairman, Medical Advisory Committee to the Jefferson County Chapter of the National Foundation for Infantile Paralysis, explained the functions of his committee, and introduced Mr. William Bade, Chairman of the Jefferson County Chapter of the National Foundation for Infantile Paralysis, who explained the purpose and operation of the Foundation. Dr. Wood then read the report of the Medical Advisory Committee. There was discussion by Joseph C. Ray, M. D., Bruce Underwood, M. D., and C. E. Reddick, M. D.

Dr. Atherton referred the report of the Medical Advisory Committee to the Executive

Committee to study and make recommendations at next meeting.

The following new members were elected:

Active Membership: Ralph M. Denham, M. D., Eugene M. Holmes, M. D., Robert B. Nolan, M. D., C. E. Reddick, M. D., William H. Smith, M. D., R. L. Woodward, Jr., M. D.

Associate Membership: Phillip D. Briggs, M. D., Seymour Cohen, M. D., Thomas S. Wallace, Jr., M. D., Gerald S. Williams, M. D., Carroll L. Witten, M. D.

The Secretary read the following communication from M. R. Cronen, M. D.:

"The Committee on Special Drugs, a branch of the Health and Welfare Council, wishes to announce to the Jefferson County Medical Society that a special fund for drugs needed for the care of indigent private patients is available by application to the Health and Welfare Council."

The Secretary read an announcement from the Veterans Hospital inviting members of the Society to attend the monthly scientific program and dinner September 20 and 21 at Nichols Hospital.

Sam A. Overstreet, M. D., President, Kentucky State Medical Association, outlined some of the major points to be brought to the House of Delegates for action at the Centennial Meeting of the K.S.M.A.

Dr. Atherton appointed R. O. Joplin, M. D., to act as chairman of the committee on delegates, to call them together and instruct them before the State Medical Meeting.

Dr. Bruce Underwood was called upon to make a few remarks about the Centennial Meeting next month. Mr. Joe Sanford also spoke about the exhibits and meetings of special interest.

E. L. Shiflett, M. D., made a motion that at subsequent meetings of the Society, as time allows, in alphabetical order, that the obituaries of each deceased member of the Society be read. Seconded. Carried.

SCIENTIFIC PROGRAM: 9:15 P. M.

"Differential Diagnosis and Treatment of Cerebral Accidents," Frank Raemacher, M. D., and H. Lester Reed, M. D.

There were questions by Harper Richey, M. D., and discussion by E. Roseman, M. D.

Adjourned: 10 P. M.

Austin Bloch, M. D., Secretary

**MUHLENBERG**

The regular meeting of the Muhlenberg County Medical Society was held September 7, 1951.

The meeting was called to order by the president, F. M. Wilson, M. D.

The minutes of the preceding meeting were read and approved.

The secretary presented a communication and an invitation from the State Medical Society for the publication of a history of the Muhlenberg County Medical Society in connection with the Centennial Anniversary of the Kentucky State Medical Association. On motion of G. H. Rodman, M. D., it was moved that further consideration be given to this.

A report from the Muhlenberg Infantile Paralysis Association requested that a Medical Advisory Committee for that group be appointed: F. M. Wilson, M. D., R. E. Davis, M. D., and G. H. Rodman, M. D., were delegated to serve.

On motion, the meeting was adjourned.

G. F. Brockman, M. D., Secretary

**SCOTT**

The Scott County Medical Society held its regular monthly meeting at the John Graves Ford Memorial Hospital on Thursday, October 4, 1951, with the following members in attendance: W. S. Alphin, M. D., H. G. Wells, M. D., E. C. Earlow, M. D., P. H. Crutchfield, M. D., and H. V. Johnson, M. D.

The minutes of the previous meeting were read and approved.

The Secretary made a report on the activities of the House of Delegates and awards made at the Centennial meeting of the Kentucky State Medical Association.

The subject of the Hospital was brought up for discussion after which Dr. Wells moved that we recommend to the Hospital Board that they employ a Supervisor of Nurses and a Business Manager for the Hospital. Carried.

The Secretary was instructed to embody in the minutes that this is the 89th. consecutive meeting of the Scott County Medical Society.

There being no further business the meeting adjourned.

H. V. Johnson, M. D., Secretary.

*In Memoriam*

**JAMES ARTHUR ORR, M. D.**

Paris

1878 - 1951

Dr. James Arthur Orr, widely known, prominent Paris physician and surgeon, died September 24, 1951. He was born in Campbellsville on January 28, 1878, and was a graduate of Vanderbilt Medical School in 1914. He was President of his class in his senior year as well as graduating with the highest honors. He moved to Paris in 1915 and became associated with the late Dr. Charles G. Daugherty. Just recently Dr. Orr received a thirty-five year service button from the L & N Railroad Company for serving that company as surgeon for that period.

In World War I, he was a Captain in the Medical Corps with the 22nd Engineers in France.

He was President of the Bourbon Medical Society, President of the Massie Memorial Hospital staff, also a member of the Southern Medical and a Fellow of the American Medical Association and was Orator in Medicine at the Kentucky State Medical Association in 1926. For thirty-five years he was a Delegate and never missed a meeting until illness last year prevented his attendance.

His only son, James Arthur Orr, Jr., is now a Freshman in the University of Louisville School of Medicine.

**ROBERT EMMETT SULLIVAN, M. D.**

Louisville

1876 - 1951

Dr. Robert Emmett Sullivan, Louisville, staff physician at Central State Hospital, died October 13th, 1951. A native of Louisville, Dr. Sullivan was born in 1876 and was graduated from the University of Louisville Medical Department in 1906. He had served in the hospital at Lakeland for ten years and previously was a medical examiner for several insurance firms for thirty-five years.



## KENTUCKY PHYSICIANS MUTUAL, INC. SCHEDULE OF INDEMNITIES

Revisions Adopted October 2, 1951

PROCEDURE	PRESENT INDEMNITY	REVISED PROCEDURE	REVISED INDEMNITY
<b>1. ABDOMEN</b>			
Repair of diaphragmatic hernia.....	\$100.00		\$150.00
Choledochotomy or choledochostomy with exploration, drainage or removal of calculus, with or without chole- cystectomy .....	100.00		150.00
Cholecystectomy: With or without exploration of com- mon duct .....	125.00	Cholecystectomy: With exploration of common duct.... Without exporation of common duct..	150.00 125.00
Choledochoplasty: Plastic repair or reconstruction of bile ducts .....	125.00		150.00
<b>4. BREAST</b>			
Radical mastectomy, including breast, pectoral muscles and axillary lymph nodes			
Unilateral .....	100.00		125.00
Bilateral .....	150.00		150.00
<b>5. CHEST</b>			
Complete thoracoplasty .....	150.00	Complete thoracoplasty (7 or more ribs) .....	150.00
<b>ADDITIONS*</b>			
		Operation on heart.....	150.00
		Esophagectomy .....	150.00
		Esophagogastrostomy .....	150.00
<b>7. EAR, NOSE OR THROAT</b>			
Mastoidectomy:			
Unilateral .....	75.00		100.00
Bilateral .....	100.00		125.00
<b>8. EXCISION OR FIXATION BY CUTTING</b>			
Arthrotomy with exploration, drainage or removal of foreign body,		Arthrotomy with exploration, drainage or removal of foreign body,	
Major joint .....	75.00	Major joint .....	75.00
		Minor joint .....	50.00
Spinal fusion .....	100.00		150.00
Menisectomy:			
Excision of semilunar cartilage of knee joint .....	75.00		100.00
Excision of Osteochondritis Dissecans,		Excision of Osteochondritis Dissecans,	
Major joint .....	50.00	Major joint .....	75.00
Minor joint .....	25.00	Minor joint .....	50.00
* Procedures for which indemnities have not previously been determined.			

PROCEDURE	PRESENT INDEMNITY	REVISED PROCEDURE	REVISED INDEMNITY
Arthroplasty; shelf operation with mechanical device (metal cup, etc.) with or without bone or fascial graft			
Major joint .....	100.00		150.00
Minor joint .....	50.00		75.00
Excision of ganglion of the wrist.....	15.00		20.00
Parotid Gland, excision .....	50.00		75.00

**ADDITIONS**

Anterior scaleniotomy .....	50.00
Excision of cervical rib.....	75.00

**9. EYE**

Cutting on extrinsic eye muscles.....	35.00	50.00
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**ADDITION:**

Operation for Detached Retina.....	75.00
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**10. FRACTURES**

The following amounts shown are for simple fractures—single or multiple. For compound fractures, the indemnity will be one and one-half times the corresponding amount shown. For fracture requiring open operation, the indemnity will be twice the corresponding amount shown.

Vertebral body, one or more.....	50.00
Humerus, surgical neck, with or without dislocation at shoulder .....	50.00
Shaft .....	50.00
Elbow, one or more bones.....	25.00
Greater tuberosity .....	25.00

The following amounts shown are for simple fractures—single or multiple. For compound fractures, the indemnity will be one and one-half times the corresponding amount shown. For fracture requiring open operation, the indemnity will be twice the corresponding amount shown, unless otherwise specified.

Humerus, surgical neck, with or without dislocation at shoulder .....	50.00	Humerus, surgical neck, with or without dislocation at shoulder .....	75.00
Shaft .....	50.00	Shaft .....	50.00
Elbow, one or more bones.....	25.00		50.00
Greater tuberosity .....	25.00		25.00
Carpal bone, one or more.....	15.00		25.00
Base of first metacarpal .....	15.00	Base of first metacarpal (Bennett).....	25.00
Femur, shaft, including supracondylar,			
Closed .....	75.00		100.00
Open .....	150.00		150.00
Mandible (including wiring) .....	50.00	Mandible (including wiring) .....	50.00
		Closed .....	25.00

**11. GENITO-URINARY TRACT**

Cystoscopic examination .....	10.00	Cystoscopic examination:	
		Without catheterization of ureters....	15.00
		With catheterization of ureters.....	25.00
Cystoscopy for removal of urinary stones or bladder tumor:		Cystoscopy for removal of urinary stones or bladder tumor:	
First operation .....	25.00	First operation .....	25.00
Each subsequent operation.....	10.00	Each subsequent operation .....	15.00
		(Individual consideration will be given to large tumors or difficult stones—Maximum \$50.00.)	



PROCEDURE	PRESENT INDEMNITY	REVISED PROCEDURE	REVISED INDEMNITY
Circumcision (limited to members 12 years of age or older).....	15.00	Circumcision .....	15.00
Cystectomy:		Cystectomy:	
Partial .....	100.00	Partial .....	125.00
Complete with anastomosis .....	150.00	Complete with anastomosis.....	150.00
Closure of vesicovaginal or vesicouterine fistula .....	100.00		125.00
Amputation of penis.....	50.00	Amputation of penis:	
		Simple .....	50.00
		Radical .....	75.00
Orchiopexy, with or without second stage Torek operation and/or hernia repair,		Orchiopexy, with or without second stage Torek operation without hernia repair:	
Unilateral .....	75.00	Unilateral .....	75.00
Bilateral .....	100.00	Bilateral .....	100.00
		With or without second stage Torek operation with hernia repair:	
		Unilateral .....	100.00
		Bilateral .....	125.00
<b>ADDITIONS</b>			
		Ureteral meatotomy .....	35.00
		Aspiration of hydrocele.....	5.00
		Exploration or removal of adrenal gland .....	150.00
		Plastic repair, renal plexis or uretero- pelvic junction .....	125.00
		Reimplantation of ureter into bladder, skin or bowel:	
		Single .....	100.00
		Bilateral .....	125.00
		Repair, vesico-rectal fistula.....	125.00
		Repair, urethral fistula:	
		To skin .....	75.00
		To bowel .....	125.00
		Incision and drainage of prostatic abscess .....	50.00
		Vas ligation .....	25.00
		Vasectomy .....	25.00
		Plastic repair, epispadias or hypospadias .....	125.00
		Urethrotomy:	
		Internal .....	25.00
		External .....	35.00

## 12. OBSTETRICS AND GYNECOLOGY

Shortening of endopelvic fascia; para- metrial fixation (Manchester).....	100.00	Shortening of endopelvic fascia; para- metrial fixation (Manchester).....	125.00
Perineorrhaphy and trachelorrhaphy ..	50.00		75.00

(The Council on Pharmacy and Chemistry of the American Medical Association has adopted the following statement of Actions and Uses and of Dosage for publication in connection with a description of Banthine Bromide for inclusion in New and Nonofficial Remedies)

## METHANTHELIN BROMIDE.—*Banthine<sup>®</sup> Bromide (Searle)*

$\beta$ -diethylmethyaminoethyl 9-xanthenecarboxylate bromide

**Actions and Uses.**—Methantheline bromide, a parasympatholytic agent, produces both the peripheral action of anticholinergic drugs such as atropine and the ganglionic blocking action of drugs such as tetraethylammonium chloride. Tolerated amounts of methantheline bromide exert side effects typical of atropine-like drugs, but cause less tachycardia, and also less postural hypotension than does tetraethylammonium chloride. Toxic doses produce a curare-like action at the somatic neuromuscular junction.

Clinical studies indicate that the drug effectively inhibits motility of the gastrointestinal and genitourinary tracts and, to a variable degree, diminishes the volume of perspiration and salivary, gastric and pancreatic secretions. It also decreases mucoprotein secretion. Like atropine, it produces mydriasis and cycloplegia when applied locally to the eye or administered systemically, but until more clinical evidence becomes available, its local use for this purpose is not recommended. The value of the drug for preventing abnormal cardiac reflexes through the vagus during thoracic surgery, or as an agent for routine preoperative medication in place of atropine, requires further investigation before final conclusions can be reached.

Methantheline bromide is indicated for clinical use whenever anticholinergic spasmolytic action is desired, provided it is not contraindicated because of its atropine-like characteristics or because of a patient's intolerance to the unavoidable side effects of such therapy. It is useful as an adjunct in the management of peptic ulcer, chronic hypertrophic gastritis, certain less specific forms of gastritis, pylorospasm, hyperemesis gravidarum, biliary dyskinesia, acute and chronic pancreatitis, hypermotility of the small intestine not associated with organic change, ileostomies, spastic colon (mucous colitis, irritable bowel), diverticulitis, ureteral and urinary bladder spasm, hyperhidrosis or control of normal sweating which aggravates certain dermatoses, and control of salivation.

Methantheline bromide produces some degree of cycloplegia and mydriasis in therapeutic doses and

therefore should not be administered to patients with glaucoma. It sometimes decreases the ability to read fine print. Xerostomia (dryness of the mouth) is a common, sometimes transient, side effect. Urinary retention of varying degree may occur in elderly male patients with prostatic hypertrophy, and some patients may have difficulty emptying the rectum. Patients with edematous duodenal ulceration may experience nausea and vomiting during initial administration of the drug. These patients should take only liquids during the institution of drug therapy. All patients should be advised of the possible occurrence of side effects. Overdosage sufficient to produce a curare-like action may be counteracted by prompt subcutaneous injection of 2 mg. of neostigmine methylsulfate.

**Dosage.**—Methantheline bromide is administered orally or parenterally by either the intramuscular or intravenous route. Parenteral administration is not advised for patients able to take the drug orally. The average initial adult dose, oral or parenteral, is 50 mg. For patients with considerable intolerance, 25 mg. may be employed. In the management of peptic ulcer, a beginning schedule of 50 mg. three times daily before meals and 100 to 150 mg. on retiring is suggested. However, the usual effective dose is 100 mg. four times daily, although some patients may require more or less than this amount. The dosage may be increased to tolerance, using dryness of the mouth as a guide, and adjusted to meet the individual response of patients. Maintenance dosage in peptic ulcer is usually considered to be about one-half the therapeutic level. In the management of other hypermotile or hypersecretory states, the dosage should be adjusted to the smallest amount which will relieve the symptoms. When spastic conditions are secondary to inflammatory or other organic lesions, therapy directed toward the cause should be employed whenever possible.

G. D. SEARLE & CO.

Tablets Banthine Bromide: 50 mg.

Ampuls Banthine Bromide: 50 mg.



PROCEDURE	PRESENT INDEMNITY	REVISED PROCEDURE	REVISED INDEMNITY
ADDITION			
Tubal ligation, bilateral, post-partum (5 days or less).....			50.00
13. GOITER			
Local excision of small cyst or adenoma of thyroid .....	35.00		35.00
With lobectomy .....	100.00		125.00
Hemithyroidectomy: lobectomy, thyroid .....	100.00	Hemithyroidectomy .....	125.00
14. HERNIA, CUTTING OPERATION			
Hernioplasty; herniorrhaphy; hernio- tomy; Inguinal, Unilateral .....	75.00		75.00
Bilateral .....	100.00		125.00
16. SKULL			
ADDITIONS			
Craniotomy, cerebral, cerebellar.....			150.00
Cranioplasty .....			75.00
Craniectomy: Osteomyelitis, skull .....			75.00
Craniectomy and cranioplasty.....			150.00
Ventriculostomy (drainage, etc.).....			50.00
Subdural Needle Tap (infants).....			15.00
Burr Hole or "Trephine" exploration...			20.00
Prefrontal lobotomy: Unilateral .....			75.00
Bilateral .....			150.00
Application of Crutchfield tongs or other traction apparatus requiring drilling into skull .....			35.00
18. TUMORS, CYSTS, ETC., REMOVAL OF			
Excision of bone cyst or chondroma....	35.00	Excision of bone cyst, tumor or chon- droma .....	35.00
Parotid Tumor, excision.....	25.00		75.00
20. OTHER ORTHOPEDIC PROCEDURES			
ADDITIONS			
Laminectomy .....			150.00
Laminotomy or interlaminar disc excision .....			100.00

Refresh...add zest  
to the hour



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Member of the American Hospital Association

FOR ALL TYPES OF NERVOUS AND MENTAL DISEASES, AND ALCOHOLISM

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Hydrotherapy. Electrotherapy. Up-to-date psychiatric methods. Electric and Insulin Shock treatments. Psychotherapy.

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Hospital Administrator  
J. F. HALLER, Manager

Registered nurses and trained personnel. Constant medical supervision. Open to members of the Medical Association.

Located on the LaGrange Road, ten miles from Louisville, on the Louisville-LaGrange bus line.

T. N. KENDE, M. D., Neuropsychiatrist  
Medical Director

T. J. SMITH, M. D., Associate



PROCEDURE	PRESENT INDEMNITY	REVISED PROCEDURE	REVISED INDEMNITY
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21. NERVOUS SYSTEM

ADDITIONS

Trigeminal nerve injection.....	15.00
Peripheral nerve injection.....	5.00
Operative neurolysis and/or anastomosis .....	75.00
Lumbar sympathectomy:	
Unilateral .....	50.00
Bilateral .....	75.00
Lumbo-dorsal sympathectomy and splanchnicectomy:	
Unilateral .....	125.00
Bilateral .....	150.00
Dorsal sympathectomy:	
Unilateral .....	100.00
Bilateral .....	150.00
Renal sympathectomy .....	100.00
Cervical sympathetic block with procaine .....	5.00
Lumbar sympathetic block with procaine .....	10.00

22. ARTERIES, VEINS

ADDITIONS

Varicose veins, complete removal of saphenous by stripping—	
One leg .....	75.00
Both legs .....	100.00
Carotid ligation .....	50.00

REVISION OF INDEMNITIES FOR MULTIPLE OPERATIONS:

If two or more surgical procedures are performed by the same physician on the same patient concurrently or immediately successively, (e. g. repair of unilateral indirect Inguinal hernia and operations for varicocele) the fee for the two or more procedures will be the greater or greatest fee plus one-half each smaller fee or fees. The fee for two or more such concurrent operations will never exceed

the maximum allowed in the member's contract, namely \$150.00. Incidental appendectomies are excluded.

REVISION OF MEDICAL RIDER BENEFITS

Medical Rider benefits shall be increased from \$3.00 to \$5.00 per day beginning on the fourth day of hospitalization as a bed patient for non-surgical illnesses, for a period not to exceed 27 days in any contract year.

# *The* JOURNAL *of the* Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 49

DECEMBER, 1951

NO. 12

## CENTENNIAL MEETING OF THE KENTUCKY STATE MEDICAL ASSOCIATION

### Transcript of Proceedings of the Regular Session of the HOUSE OF DELEGATES

Columbia Auditorium, Louisville, Kentucky, October 1-3, 1951

(The 1951 meeting of the House of Delegates of the Kentucky State Medical Association convened at seven o'clock p.m. at the Columbia Auditorium, Louisville, Kentucky, Dr. Hugh L. Houston, Murray, Kentucky, presiding:)

**SPEAKER HOUSTON:** Will the House please come to order. It is the privilege of the speaker to open this first House of Delegates meeting of the 1951 session, the Centennial Meeting, hundredth birthday of our Kentucky State Medical Association.

The first order of business is the preliminary report of the Committee on Credentials, Dr. H. V. Johnson. Dr. Johnson.

**DR. JOHNSON:** The Committee on Credentials is very happy to report we have examined the credentials and find everything in order and there is a quorum present tonight.

**SPEAKER HOUSTON:** We have a quorum for the transaction of business by this organization. We would like to state that it is our plan to use a reference committee system of handling the resolutions, reports of officers, and so forth that come to our attention. Your speaker has appointed the reference committees who will study each and every report that comes to your attention tonight and new business that may come to your attention. If you will look on page 19 of your instructions, you will find the personnel of these committees. I would like to call the names of the doctors serving on these committees for the reason that they will be carrying a heavy load of responsibility at this meeting.

Reference Committee number 1, which will handle the reports of officers and councilors—we have Dr. E. M. Howard, Harlan, Chairman; Dr. Thomas V. Gudex, Louisville, Vice-Chairman; Dr. Luther Bach, Newport; Dr. Theodore L. Adams, Lexington; Dr. Robert L. Reeves, Paducah.

Reference Committee number 2, which will handle the reports from standing committees, Dr. W. Vinson Pierce, Covington; due to the loss of Dr. Yates I have asked Dr. Herbert L. Clay, Louisville, to serve as Vice-Chairman; Dr. Ralph L. Cash, Princeton; Dr. Robert A. Orr, Mayfield; and Dr. Rankin Blount, Lexington.

Reference Committee number 3, which will have the reports of special committees, we have Dr. Walter L. O'Nan, Henderson, Chairman; Dr. Richard J. Rust, Newport, Vice-Chairman; Dr. Arthur R. Kasey, of Louisville; Dr. Keith P. Smith, Corbin; and Dr. B. Ralph Wilson, Sharpsburg.

Reference Committee number 4, which is to handle the reports of the advisory committees, we have Dr. George W. Pedigo, Louisville, Chairman; Dr. Frank L. Duncan, Monticello, Vice-Chairman; Dr. Leon Higdon, Paducah; Dr. Harry K. Dillard, Warsaw; Dr. H. B. Mack, Pewee Valley.

Reference Committee number 5, which will catch the resolutions that are brought in to the committee, Dr. Charles B. Stacy, Pineville, Chairman; Dr. Howell J. Davis, Owensboro, Vice-Chairman; Dr. James A. Outland, Murray;



Dr. John D. Handley, Hodgenville; Dr. John W. Scctt, Lexington.

Before the Chair proceeds further, I would like to have a motion approving the appointment of the filling of the vacancies on these committees so that we can proceed to refer work to them. May I have a motion to approve these appointments?

(A motion was so made, was regularly seconded, was put to vote and carried.)

**SPEAKER HOUSTON:** We will have the reading of the minutes of the 1950 meeting. As you well know, they were printed in the December 1950 issue of your Journal, which was Volume 48, Number 12. Do I have a motion that we accept these minutes as printed in our Journal, or do you wish them read?

(A motion was so made, was regularly seconded, was put to a vote and carried.)

**SPEAKER HOUSTON:** We will now hear from our President, Dr. Sam A. Overstreet, Louisville. Dr. Overstreet.

**DR. OVERSTREET:** You have my printed report, which is rather brief, and I think that I have nothing to add to that. It can be read in a very few minutes and I think it will comprise all I have to offer.

#### **REPORT OF THE PRESIDENT TO THE**

#### **1951 SESSION OF HOUSE OF DELEGATES**

The Kentucky State Medical Association during the past year has made significant progress as below outlined:

First, the Council has heartily approved the plans of the Secretary and General Manager, Dr. Bruce Underwood, for an expanded and efficient program.

Second, an effort has been made consistently to place before the individual members of our profession the need for improved medical care throughout the state and comprehensive program for this end is being outlined.

Third, much time and thought have been expended to proper celebration of the Centennial of the Kentucky State Medical Association at our annual convention, October 2, 3, and 4, 1951.

Fourth, the closest coordination of activities between the Kentucky State Medical Association and the Medical School of the University of Louisville has been sought.

Fifth, the President has sought and obtained invaluable advice and aid from innumerable members of the Association and in no individual case has cooperation and encouragement been refused. It is believed that individual members of our Association wish to go forward

in a coordinated plan of better medical service to the people of our state. They unreservedly approve the progressive policies of the Commissioner of Health in this regard and pledge to him the continued cooperation of our Association.

Respectfully submitted,  
/s/ Sam A. Overstreet  
Sam A. Overstreet, Louisville  
President.

**SPEAKER HOUSTON:** I will refer Dr. Overstreet's report which you have to Reference Committee number 1. We will now have the report of the President-Elect, Dr. Clark Bailey of Harlan.

**DR. BAILEY:** Mr. Speaker, the printed report that is in your folder—I do want to call your attention to the last paragraph in it. "It is my hope that each member of the Kentucky State Medical Association may be thoroughly enlightened as to our functions and purposes so that we may work as a unit in the defense of our inherent right to faithfully serve the people we love."

#### **REPORT OF THE PRESIDENT-ELECT TO THE**

#### **1951 SESSION OF HOUSE OF DELEGATES**

It has been my privilege to attend several District and County Society meetings during the past year in addition to the regular and called meetings of the Council. A tremendous amount of constructive work is done by the doctors constituting the different committees of the Association. It is through their sincere efforts that our profession in Kentucky is marching forward in spite of the increasing number of obstacles in our path.

It is my hope that each member of the Kentucky State Medical Association may be thoroughly enlightened as to our functions and purposes so that we may work as a unit in the defense of our inherent right to faithfully serve the people we love.

Respectfully submitted,  
/s/ W. Clark Bailey  
W. Clark Bailey, Harlan  
President-Elect

**SPEAKER HOUSTON:** Thank you, Dr. Bailey. The report of the President-Elect will be referred to the Reference Committee number 1. The Speaker's report is in your folder and I will now officially refer it to Reference Committee number 1.

#### **REPORT OF SPEAKER OF THE HOUSE OF DELEGATES TO THE 1951 SESSION OF HOUSE OF DELEGATES**

By authority of the new Constitution adopted by this House in 1950, the office of Speaker of

the House of Delegates was created. At the last meeting of this body I was elected your first Speaker to preside over your deliberations beginning with the Centennial Meeting in 1951. The term of office is for three years. Your second Speaker will be elected in 1953.

During the past year it has been my duty to work with the central office in encouraging the county societies to elect their delegates early and to take an active part in the planning for this Meeting and in the affairs of our Association.

The Speaker is charged with the duty of appointing the nominating committee and the five reference committees. I have used my very best judgment in appointing these committees, and I do trust they will serve the Association in a way pleasing to the majority of our members. Under the new Constitution, a great deal of authority has been taken from the officers and the two meetings of the House and assigned to the committees. Please carry your discussions on vital problems before the Association to the committees assigned to study and recommend solutions for these problems.

My first report must, of necessity, be brief as my main duty consists of presiding over your meetings. May each member of the House of Delegates find me fair and unbiased and forever conscious of the will of the elected delegates of this Kentucky State Medical Association.

Respectfully submitted,  
/s/ Hugh L. Houston  
Hugh L. Houston, Murray  
Speaker of the House of Delegates

**SPEAKER HOUSTON:** We are now ready for the report of the Council, nominations for the Distinguished Service Award, nominations for the E. M. Howard Award, nominations for the J. Watts Stovall Award. Dr. C. C. Howard, Glasgow.

**DR. HOWARD:** Mr. Speaker, gentlemen, the Council's report is in your folder, and it has been referred to the Committee.

### REPORT OF THE COUNCIL TO THE

#### 1951 SESSION OF HOUSE OF DELEGATES

This report consists of a summary of the most important transactions of the Council during the year 1950-1951.

**FIRST MEETING.** Immediately following the second meeting of the House of Delegates Wednesday, September 27, 1950, at which time the state was re-districted and four new districts added, the new Council held its first meeting in the Columbia Auditorium. At this session, C. C. Howard, M. D., was re-elected

Chairman, and J. Farra Van Meter, M. D., Vice-Chairman. Bruce Underwood, M. D., was re-elected General Manager of the Council. An honorarium for K.S.M.A. employees who had assisted in the preparations for the meeting was approved by the Council, and Sam A. Overstreet, M. D., Chairman of the Centennial Committee, gave a detailed description of Centennial plans. The unveiling of the Dr. Philip E. Blackerby portrait, it was decided, should be held as soon as it was convenient to arrange a meeting of the Council and Mrs. Blackerby.

**SECOND MEETING.** The second meeting of the Council was held in the Headquarters Office on Thursday, December 28. The report of the Secretary and General Manager called attention to Dr. Overstreet's efforts to get more K.S.M.A. members to pay A.M.A. dues and that the Kentucky Medical Directory was now being prepared. The Secretary explained his acute need for a Deputy Health Commissioner due to the departure of Dr. Kelso.

The Council heard a report and discussed at length the activities of the Barrow Foundation of Lexington that has a plan for the operation of local hospitals. The Council voted to urge that local control of hospitals be maintained in all instances. Much consideration was given to the request for K.S.M.A. membership by members of the Blue Grass Medical Association, after a committee who had met with the colored physicians reported its findings. The same committee and the By-Laws Revision Committee was directed to continue to work on the problem.

Plans for the County Society Officers Conference, to be held at the Brown Hotel, March 1, were explained. Dr. Overstreet reported at length on the development of Centennial plans, and additional funds in the amount of \$5,000 were authorized to help finance the Centennial.

The Council voted to pay the membership fees of members who were in good standing on entering military service. At this meeting, it was voted to establish an Executive Committee to facilitate the work of the Council. The Committee was made up of the Chairman of the Council, the President of the Association, the Secretary and two Council members.

The Secretary discussed the reserves of the Association and asked that the Executive Committee be authorized to investigate the matter of raising dues. Dr. Underwood also told the Council that, for the first time, a budget was being drafted for the Association and would be presented at a subsequent meeting of the Council.



The need for the restatement of the Association's aims was described to the Council by the Secretary, and the Council authorized the President to prepare a proposed statement of policy and present it at a later meeting of the Council. A. Clayton McCarty, M. D., Chairman of the Advisory Committee (Procurement), reported on the needs of the Armed Forces for medical personnel. Dr. Bailey rendered a report of the activities of the House of Delegates of the A.M.A. at the Cleveland meeting.

The Council granted permission for the Journal to carry articles on Public Health to be signed by the Commission. The Secretary explained the A.M.A. ruling on membership which made the K.S.M.A. eligible for a third delegate for 1951. The Council then authorized Dr. Underwood to serve as its third delegate to the A.M.A. House of Delegates until the next meeting of the House of Delegates of the State Association. The legislative program of the Association was discussed, and the Executive Committee was authorized to study the legislative needs of the state and report back to the Council.

Operation of the state tuberculosis hospitals by the Sanatoria Commission was discussed at length. The Council asked that a letter be drafted to Governor Wetherby explaining that various segments of the population were unhappy with the present method of operation of the hospitals and pointing out that the Council would like to see a better feeling toward the hospitals, which could come only from more efficient operation of them.

The status of the Trachoma Hospital at Richmond was discussed, and Hugh Mahaffey, M. D., of Richmond, was asked to investigate the various possibilities for the disposal of the property, since it was no longer being used.

Other matters considered at the meeting were the Solomon proposal, the request that the Grievance Committee change its name to the Professional Relations Committee, which was granted, and the report by Vernon Pace, M. D., Councilor for the First District, on the operations of the Blue Cross Pittsburgh Plan at Paducah. The Medical Economics Committee was asked to investigate the situation described by Dr. Pace. The Council agreed to meet again May 10 in regular session.

**THIRD MEETING.** The third meeting of the Council was a called meeting and was held March 1 at the Brown Hotel a few minutes before the first annual County Society Officers Conference took place. The session was called so that the K.S.M.A. might suggest nominees for the Director of Mental Hospitals and Mental Hygiene, in accordance with the provisions of

the Chandler Wallace Act. The Chairman of the K.S.M.A. Committee on Mental Hospitals and Mental Hygiene, Spafford Ackerly, M. D., recommended the names of the following physicians: Frank M. Gaines, John P. Bell, and Donald F. Moore. This recommendation was accepted.

Other matters included authorizing the President to write the Governor and members of the Legislature of the Council's approval of the Appropriations Bill and the extension of Social Security benefits to state employees.

**FOURTH MEETING.** The Fourth Meeting of the Council was held Thursday, May 10, in the Headquarters Office. The Secretary included in his report the following information: The Kentucky Physicians Mutual, Inc., had paid back in full the loan the Association had made to the company at the time of its organization; the attempt to get Governor Wetherby to include appropriations for Public Health at the special Legislature session had failed; that Dr. Gaines had been appointed Director of Mental Hospitals and Mental Hygiene; the introduction of a Deputy Health Commissioner, C. E. Reddick, M. D.; and a request that he be allowed to delegate more duties to the Executive Assistant, which was approved. In addition, the matter of selecting Awards was discussed, and the cost of the Journal was considered. It was voted to allow licensed interns and residents in Kentucky to become full members for the rate of \$5.00 per year while they were having their hospital training.

The Executive Assistant reported on membership activities and pointed out that the Veterans Administration Hometown Medical Care contract was up for renewal, and the Council authorized the renewal of the contract.

Dr. Howard gave a report of the February 22 meeting of the Executive Committee. Dr. Underwood explained his activities concerning legislation and asked for a legislative committee. The Council authorized the formation of such a committee, and Hugh L. Houston, M. D., Murray, was named chairman of the committee and asked to select other members for the committee from the membership as needed.

Gaithel Simpson, M. D., Chairman of the Committee on Medical Economics, gave his report, which included a statement that the Committee has been assisting in the promotion of Blue Cross, that it had considered the Blue Cross Pittsburgh Plan in operation at Paducah, that efforts had been made to get county fiscal courts to pay for the hospitalization of indigents in their counties, that his committee had met with the State Commissioner of the Department of Economic Security and it had been decided to set up a council to view some

of the medical problems of the clients of the economic security administration.

He said that his committee had studied the problem of expanding medical education in Kentucky, and that it had made some study of the activities of the United Mine Workers Health and Welfare Fund.

Dr. Overstreet expressed to the Council his concern over the need for expanding medical education in Kentucky and the results of his investigation in this field. He said that he had unofficially invited Donald G. Anderson, M. D., and Francis R. Manlove, M. D., of the A.M.A. Council on Medical Education, to explore the situation in Kentucky and make recommendations as to what the best approach to the problem was. He asked the Council to meet in an all-day session to consider this problem. After discussion, it was decided to have a called meeting on May 30.

Clyde Sparks, M. D., Ashland, reporting as Chairman of the Advisory Committee on Health Insurance, said his committee had met with Department of Insurance officials at Frankfort relative to the Council's feeling that it might be well to select ten or twelve insurance companies writing medical payments on hospital care insurance. The purpose of the investigation was to determine a list of these companies and send them to the membership so that they might recommend these companies to patients in situations where Blue Cross was not operating. Dr. Sparks said the insurance officials were of the opinion that the new law, which went into effect September 1, 1950, would take care of the situation

in a few months, and the rating of the companies was not indicated. Dr. Overstreet reported on the activities of the Centennial Committee and the Committee on Scientific Assembly. At this point Dr. Underwood explained to the Council the proposed budget for the Fiscal Year July 1, 1951, to June 30, 1952. Below is an abstract of the proposed budget.

It was pointed out that with the present expanded program of the Association we were operating this year with an approximate deficit of \$27,690.00. Of course, due to the added expenses of the Centennial, between eight and ten thousand of this will be a non-recurring expense. The Council then considered the matter of raising state dues, and the Secretary pointed out that the average state medical association individual dues were \$32.67 per year. After much discussion, it was decided that the Council would recommend to the House of Delegates that the state dues be raised from \$15.00 to \$25.00 per year.

Branham B. Baughman, M. D., Frankfort, at the request of the Executive Committee, gave a report of his investigation of the Trachoma Hospital. It was agreed that Dr. Baughman should contact Mr. Goodlet, a Frankfort attorney, relative to the possibility of disposing of the Trachoma Hospital, and use the proceeds on some health program that would, in essence, carry out the wishes of the will of the donor of the property to the Association.

Dr. Overstreet reported on the tuberculosis sanatoria situation, explained that the Public Relations Committee was working on a policy

ESTIMATED ASSETS AS OF JULY 1, 1951

CASH ON HAND .....		\$ 28,525.00
<b>Checking Account</b> .....	\$ 6,025.00	
Current Fund Account .....	\$ 3,000.00	
Journal Account .....	25.00	
Annual Meeting Account .....	3,000.00	
<b>Savings Accounts</b> .....	\$22,500.00	
INVESTED RESERVES .....		\$ 32,136.10
U. S. Government Bonds .....	\$31,295.60	
Louisville Title Mortgage .....		
Co. Common Stock .....	840.50	
<hr/>		
TOTAL OF CASH ON HAND PLUS		
INVESTED RESERVES .....		\$ 60,661.10
PROPERTY .....		\$ 34,936.78
McDowell House (Appraised Value) .....	\$25,000.00	
McDowell Home Furnishings		
(Appraised Value) .....	5,000.00	
Library (Estimated Value) .....	480.00	
Office Equipment (Depreciated Value) ....	4,456.78	
<hr/>		
GRAND TOTAL OF ALL ESTIMATED		
ASSETS .....		\$ 95,597.88



## ESTIMATED INCOME AND EXPENSES, JULY 1, 1951-JUNE 30, 1952

	Estimated Income	Estimated Expenses
ITEM I—Current Fund Account .....	\$ 32,900.00	\$ 47,705.00
ITEM II—Journal Account .....	14,150.00	14,410.00
*ITEM III—Annual Meeting Account .....	8,800.00	15,000.00
ITEM IV—Officers, Delegates, Councilors and Miscellaneous Committee Account .....	.00	2,925.00
ITEM V—Educational Campaign Committee Account .....	.00	2,000.00
ITEM VI—Postgraduate Education Account.....	.00	1,000.00
ITEM VII—Woman's Auxiliary Account .....	.00	500.00
<b>TOTAL ESTIMATED EXPENSES .....</b>		<b>\$ 83,540.00</b>
<b>TOTAL ESTIMATED INCOME .....</b>		<b>55,850.00</b>
<b>DEFICIT .....</b>		<b>\$ 27,690.00</b>

\*Centennial expense of \$9,500.00 included which will be non-recurring.

statement and described the problems confronting the Committee on Scientific Exhibits. The Council authorized the expenditure of \$3,500 for these exhibits for the Centennial Meeting.

The matter of providing membership in the State Association for colored physicians was discussed by Dr. Howard. After discussion, it was agreed that the Council would ask the By-Laws Committee to work out a plan whereby a statewide component society would be chartered for colored physicians. Also, that those counties who might want to accept colored physicians locally be permitted to do so. The matter was referred to the Committee for the Revision of the By-Laws.

Dr. Underwood presented the report of the Committee on Tuberculosis, which recommended that an Appeal Board be set up to operate in connection with admissions of patients refused by the Sanatoria Commission. The Council endorsed the proposal. The second suggestion by the Committee asked that small x-ray units of the State Department of Health be allowed to go into all counties. This proposal was also endorsed by the Council.

The Council voted to form a committee to stimulate contributions to the A.M.A. National Education Foundation from members of the Association, and the chairman was authorized to appoint such a committee. The Council then authorized the formation of a state Diabetic Detection Committee and endorsed the program of Diabetic Detection. It heard a report from the Executive Assistant covering the benefits that might be derived from a telephone postgraduate course on a statewide basis and authorized the investigation of the matter.

Dr. Howard discussed the results of his studies in the field of accident prevention, and

the interest the Southeastern Surgical Congress had in the matter. He explained his three-point safety program which included the training of ambulance attendants in first aid. The Council accepted Dr. Howard's recommendation and passed a motion calling for K.S.M.A. cooperation with all agencies working for the prevention of accidents.

A discussion on the matter of grading hospitals was presented by Dr. Howard, and the Council accepted Dr. Howard's recommendation that the Association go on record as being in favor of official grading of hospitals being in the hands of the medical profession. With this, the meeting adjourned.

**FIFTH MEETING.** The Council met in a called session in the Headquarters Office to consider the expansion of medical education in Kentucky. Letters were read discussing this subject by the Secretary from the chairman of the Committee on Medical Economics and absent members. Dr. Overstreet, after thanking the Council for attending the meeting, discussed the report of the unofficial investigation of Donald G. Anderson, M. D., and Francis R. Manlove, M. D., of the A.M.A. Council on Medical Education and Hospitals. (Council members had previously received a copy of the report.) According to Dr. Overstreet, these men felt that a second school might well be established in Lexington. Dr. Overstreet felt that perhaps such a move would go a long way toward the permanent solving of the problem.

Dr. Kinsman discussed existing physical problems on increasing enrollment in his school, and indicated with improvements and additions, the enrollment of the freshman class could be increased from the September, 1951, quota of 100, to 125. He thought enrollment

should not go beyond that, since it was felt that larger classes did not serve the best interests of the student or medicine as a whole. He indicated he would support the second school if the University of Louisville could count on continued state support. He felt there were reasonable assurances from the officials of the city that if a second school was not established and the amount of support from the state was adjusted, the City would no doubt undertake additions to the present plant of the medical school.

After all of those present were given an opportunity to express themselves, the Council went on record as not being in favor of establishing a second school at Lexington at this time. Recommendations looking toward improvement of the local School were discussed, approved and the action was referred to a designated agency of the Association for implementation. Continued study of the problem by Dr. Overstreet's committee was asked, and the Council formally expressed its appreciation to Dr. Overstreet for his interest and effort.

Dr. Underwood, in his report to the Council, recommended that the deadline for county societies submitting delegates to the Headquarters Office eligible for serving on the reference committees at the Annual Meeting be made as of April 1st. The recommendation was accepted. Dr. Underwood expressed satisfaction at Governor Wetherby's attitude toward making an emergency appropriation to public health. Following a discussion involving the matter in increased state support to indigent medical care and public health, the Council accepted Dr. Underwood's request that the Legislative Committee look into the situation. Dr. Underwood then explained the problem which the Board of Health faces in dealing with instances of improper professional conduct on the part of individual members of the profession, and pointed out the advantages of the Association undertaking to keep its own house in order. Following discussion the Council voted to refer these "problem cases" to the Professional Relations Committee. This Committee was instructed to investigate these problems when referred to it by the State Board of Health and report its findings to the Council, which in turn would make recommendations to the Board.

Dr. Overstreet pointed out the need for closer cooperation between the Association and the Medical School. He asked Dr. Kinsman to speak on this matter; Dr. Kinsman, in turn, asked the Council to set up an associational committee to deal with such matters. The recommendation was accepted.

Developments in the Trachoma Hospital situation were explained by Dr. Underwood. It was voted to accept the proposal of the Madison County Medical Society that it would make that society the agent of the Association with power to undertake the disposal of the property and the relocation of the proceeds derived therefrom, and, at the same time, accept the responsibility for all expenses incident to insurance, maintenance and such costs as would grow out of the development of their plans.

**SIXTH MEETING.** The Council met in a called session in the Headquarters Office, Wednesday, August 29, at 2:15 P. M., to consider additional material on the matter of the expansion of medical education in Kentucky. John S. Chambers, M. D., of the University of Kentucky at Lexington, who had made studies on the problem for some years, was introduced. Complimenting the work and record of the local medical school, Dr. Chambers discussed his thinking on the need for a second medical school in Lexington, and the building of a large hospital there by the state as part of a proposed development of the County Unit system in the care of the indigent. He stated he felt that the people would accept a carefully worked out, long-range plan.

The views of the Committee on Medical Economics were given the Council and a discussion followed dealing with the over-all picture, including medical education, indigent medical care and public health. Following thorough consideration, the Council voted to ask the Committee on Medical Economics to study the composite picture with the view of establishing priority to each need. It was further instructed to appoint such subcommittees as it would need in the study—such subcommittees reporting to the Committee on Medical Economics.

**SEVENTH MEETING.** The Council met in regular session, Thursday, August 30, at 10:00 A. M., in the Headquarters Office. Dr. Underwood introduced Mr. Raymond M. Jones, the new Field Secretary, to the Council, and explained it was not possible to unveil the Blackerby portrait at this meeting. He told the Council the colored people had been informed that the structure of the Hospital Bill would not be altered to include a clause governing the acceptance of patients. He stated the State Board of Health had conducted satisfactory negotiations with Blue Cross on the Blue Cross Pittsburgh issue. He was authorized to discuss with Kentucky Education Association officials the A.M.A. resolution on teachers, and was directed by the Council to put on the October 1 meeting agenda of the Council, the selection of nominees pertaining to filling an



expiration of a physician member of the State Board of Health. The Council accepted his request that an agency of the Association be instructed to work with the State Hospital Council, and named the Hospital Committee for the work. It was stipulated that three physicians from rural areas be added to the personnel of the Hospital Committee.

The Executive Assistant reported on the membership status, that \$8925.00 in rentals had been contracted for by technical exhibitors at the Centennial Meeting, making a new all-time high, and told the Council of his investigation into the question as to whether the Association should register as a lobbyist in Washington. The Council voted to abandon the idea. Mr. Sanford asked that the date of February 7, 1952, be approved for the next County Society Officers Conference, and October 6, 7 and 8 be approved as the 1953 meeting date—both were accepted by the Council. Mr. Raymond Dixon, Associate Editor of the Journal, discussed plans for the Centennial Journal. Dr. Overstreet told of the final stages of plans for the Centennial Meeting and urged support of the membership in the matter of purchasing the Centennial Volume.

At the coming meeting of the House of Delegates, it was recommended that the Nominating Committee name at least one man for each office, and that the House be asked to name alternate delegates to the A.M.A. The Council authorized the Headquarters Office to mail information on need for the raising of dues to each county society delegate, President and Secretary, and it authorized the preparation of a sketch of each nominee for one of the three Awards to be prepared and presented to the House of Delegates.

Dr. Houston reported on the activities of the Legislative Committee and explained that the Committee had no intention of involving the Association in partisan politics and that the Committee was limiting itself strictly to the legislative aims of the Association that were in the public interest. Dr. Underwood discussed some of the legislative aims of the Association and dealt with the need for the modernizing of some of the existing statutes. It was pointed out that legislation to strengthen the law on the care of indigents was needed. The Council accepted the recommendation that the firm of Mullican & Company be employed to advise the Association on matters of public relations, and authorized the employment of Vincent Goodlet, a Frankfort attorney, as counsel for the Association. The Council then expressed itself as being in favor of placing the operation of the State tuberculosis hospitals under the Tuberculosis Division of the

State Department of Health. Dr. Howard reported on the progress being made in the matter of training and registering ambulance attendants through the local county health departments.

Dr. Underwood explained the recommendations of the By-Laws Revision Committee relative to accepting colored members of the Association.

Dr. Vance, representing the Professional Relations Committee, reported on an investigation the committee had made of two Kentucky physicians as a result of the directive of the Council at the May 30 meeting. Dr. Overstreet presented the recommendations of the Public Relations Committee which was being made in response to a Council directive asking for a policy statement. The Council approved the statement of "Twelve Objectives of the Association," which is as follows:

## **TWELVE OBJECTIVES OF THE KENTUCKY STATE MEDICAL ASSOCIATION**

### **ETHICS**

1. To constantly improve the high standard of ethics of our profession and inspire by example and precept among medical students and young practitioners a sanctity of the trust committed to us.

### **CITIZENSHIP**

2. To encourage the members of our profession to participate in local activities of civic improvement and building of good American citizenship.

### **LEADERSHIP**

3. To assume an alert leadership in all matters pertaining to health to the end that we may provide for all Kentuckians the best medical care which the State's resources will afford.

### **COOPERATION**

4. To secure the cooperation of all professions and agencies in a constructive and progressive program of health throughout the state.

### **PREPAID CARE**

5. To promote prepaid hospital and sickness insurance to individuals as well as groups through our own and reputable private agencies.

### **THE PUBLIC**

6. To inform the public of the problems of medical service and how they may secure the best medical care, and to solicit their confidence and cooperation in efforts devoted to their best interest.

### **INDIGENTS**

7. To provide more equitable and adequate medical care for indigent citizens in every community.

## PUBLIC HEALTH

8. To actively cooperate with the State Department of Health and with local health departments in initiating and carrying out a sound public health program designed to control preventable disease and to safeguard the health of the people.

## INSTITUTIONS

9. To constantly promote the improvement of curative medical care in our State Tuberculosis and Mental Hospitals and to coordinate and support programs that combat heart disease, cancer, diabetes, poliomyelitis, and other similar devastating diseases.

## HOSPITALS

10. To expand and improve present hospital facilities to the end that all citizens may have available within their reach the benefits of the best scientific diagnosis and treatment of disease.

## EDUCATION

11. To educate an adequate number of physicians, nurses, and technicians and seek their more equitable distribution to all communities; to foster medical research and extend to all the benefits of postgraduate study.

## LEGISLATION

12. To maintain close liaison with the Federal, State and County governments to the end that the best health interests of our citizens will be served.

The Council refused to endorse the recommendation of the National Doctors Committee for Improvement of Federal Medical Service, and voted to support the A.M.A.'s position on this issue.

As a result of the May 10 directive, Mr. Sanford reported on plans for the Association to offer, with the cooperation of the University of Louisville Medical School, telephone postgraduate courses to the County Medical Societies in February, March and April. He asked that a committee be assigned to supervise this matter, and the Council approved the plans for the course as outlined. The Council also named the Committee on Medical Education to work with him in the setting up of the programs.

Dr. Bailey reviewed some of the potent dangers to the present system of the practice of medicine in general and explained conditions in Harlan County that illustrated these dangers. He asked that a committee be appointed to study the over-all picture, and asked that special attention be given to practice in his section as an immediate problem. The Council accepted the recommendation, and the committee was authorized to undertake the study.

Mr. Sanford told the Council of the plans the recently activated Diabetic Committee had

for the State's participation in the National Diabetic Detection Drive, and stated that the Committee would like to have the Council's endorsement of the plans. The endorsement was granted.

Dr. Underwood discussed the advantages of some form of membership by the Association, or representatives of it, in the Better Business Bureau. The Council directed that the Association or some member of the Headquarters Staff become a member of the Bureau. As a result of a request of the World Medical Association, a committee chairman was appointed, with instructions to name others on the committee, to stimulate K.S.M.A. members to join the W.M.A. Dr. Howard appointed Dr. Bailey, of Harlan. The Secretary said the next meeting of the Council would be October 1, at the Brown Hotel.

Respectfully submitted,

/s/ C. C. Howard

C. C. Howard, M. D., Chairman

**SPEAKER HOUSTON:** The report of the Council will be referred to Reference Committee number 1. If you have any discussion about the functions of the Council or its actions for the past year, please carry your discussions to that reference committee at its regular meeting Tuesday afternoon.

Dr. Howard, will you give us the nominations for the Distinguished Service Award?

**DR. HOWARD:** These nominations for the Distinguished Service Award given by the State Society this year—we had four nominations for this award, and we submit to you those four.

The first nomination was Dr. Carl Norfleet of Somerset. I will give you a brief sketch of each one.

Dr. Norfleet was born at Faubush, Pulaski County, April 13, 1881.

He graduated from Hospital College of Medicine, Louisville, July 1905 and received his license the same year.

He engaged in private practice in Silerville, Kentucky, from 1905 to 1908, then in Somerset, Kentucky, from 1908 until 1917, at which time he entered military service as captain, U. S. Army Medical Corps.

In 1919, he took postgraduate work at the Chicago Polyclinic.

In 1925, he became Assistant Surgeon at the Somerset General Hospital and in 1929 became Surgeon and General Manager of that hospital.

He is a member of the Pulaski County Medical Society, the Kentucky State Medical Association, the American Medical Association, the Southern Medical Association, the Associa-



tion of Railway Surgeons and a member of the Public Health Association since its organization.

He has served several times in the House of Delegates of the K.S.M.A., and as Councilor of the Seventh and the newly organized Twelfth District.

He has been a member of the Pulaski County Board of Health approximately forty years and of the Medical Economics Committee for more than ten years.

The second nomination is Dr. John W. Scott of Lexington. Dr. Scott was born in Lexington, Kentucky, January 31, 1875.

He graduated from the Medical Department of Columbia University in 1896, received his license in 1898, served his internship at Bellevue Hospital, New York City, 1896-1898 and began his practice in Lexington in 1898.

Dr. Scott was a captain in the Medical Corps of the U. S. Army at Camp Taylor in 1918-1919.

President, Fayette County Medical Society, 1906.

Orator in Medicine for K.S.M.A., 1919. President, Kentucky State Medical Association, 1939.

Is a Fellow of the American Medical Association and was a member of the Committee of Scientific Awards in 1942 and 1944.

Is a Fellow of the American College of Physicians and is a member of the Central Society for Clinical Research, serving as its Councilor, 1943-1946.

Is a member of the Scientific Council of the American Heart Association.

Is now Chief of the Medical Service of both the Good Samaritan and St. Joseph Hospitals, Lexington.

The third is Dr. William O. Johnson of Louisville, Kentucky. Dr. Johnson was born in Winchester, Kentucky, 1894.

He graduated from the Johns Hopkins School of Medicine in 1920 and received his license in 1926. From 1924 to 1926 he served his internship and residence at Lakeside Hospital, Cleveland, Ohio, and from 1924 to 1926 at the Cleveland Clinic Hospital on the surgical staff. He began his practice in Louisville in 1926.

Dr. Johnson was professor of gynecology at the University of Louisville and considered the founder of the Kentucky Gynecological Society.

During World War II he served as Major in the Army Medical Corps.

Fourth, Dr. E. M. Howard, born August 5, 1886, in Harlan, Kentucky.

He graduated from the Medical Department

of the University of Louisville in the class of 1908, received his license in 1908 and began practicing in Harlan.

Dr. Howard for many years has been a leader in Public Health and organized medicine in his state.

Dr. Howard was appointed to the State Board of Health in 1928, and in 1929 was elected President of this organization, and has held that office until the present date.

He was President of the Kentucky State Medical Association in 1942, and has attended more than thirty of its meetings. He has been a member of the House of Delegates of the K.S.M.A. for more than twenty years.

Dr. Howard is a member of the Advisory Committee for Mental Health and the Ephraim McDowell Committee. He was Orator in Surgery at the 1923 annual meeting.

Dr. Howard received six nominations for the K.S.M.A. Distinguished Service Award.

SPEAKER HOUSTON: We now have four nominations for the Distinguished Service Award, Dr. Carl Norfleet, Dr. John W. Scott, Dr. William O. Johnson, and Dr. E. M. Howard.

(Thereupon three tellers were appointed by the speaker.)

SPEAKER HOUSTON: We will declare the balloting closed. While the tellers are counting the Distinguished Service votes, I will ask you to give us a nomination for the E. M. Howard Award.

DR. HOWARD: There are two nominations for the E. M. Howard Award, Dr. Charles K. Brosheer of Middlesboro, born in Bell County in 1873.

He graduated from the University of Nashville School of Medicine in 1900, received his license and began his practice in 1901 in Middlesboro, Kentucky.

In 1919, Dr. Brosheer, in association with U. G. Brunnet, founded the Middlesboro Hospital. This hospital had fifty beds and in earlier days a school of nursing.

About 1930, Dr. Brosheer organized the original Bell County Cancer Clinic.

Dr. Brosheer is now, and has been throughout his active practice, a member of the following organizations:

The Bell County Medical Society

The Kentucky State Medical Association

The Southern Medical Association

The American Medical Association

The second nomination, Dr. J. B. Lukins, of Louisville, born at Mt. Carmel, Fleming County, Kentucky, November 4, 1881.

He graduated from Hospital College of Medicine in Louisville, in 1906, and began his practice the same year.

Dr. Lukins has represented our Association through his work in the American Medical Association, the Southern Medical Association and the Southeastern Surgical Congress. His contribution to county medical society activities is well known.

He was an Associate Professor of Gynecology at the University of Louisville School of Medicine for forty years. For twenty-seven years he has been Chairman of the Medico-Legal Committee of the Association.

Dr. Lukins was President of the Kentucky State Medical Association in 1935 and is a delegate to the American Medical Association. At present, he is a member of the Judicial Council of the American Medical Association.

Dr. Lukins received 10 nominations for the E. M. Howard Award.

**SPEAKER HOUSTON:** The balloting is now closed for the E. M. Howard Award. Dr. Howard, will you give us the nominations for the J. Watts Stovall Award?

**DR. HOWARD:** There are four nominations for the J. Watts Stovall Award. The first one, Dr. Clement V. Hiestand of Taylor County, Campbellsville, Kentucky, was born May 26, 1872.

He graduated from the Louisville Medical College in 1896, received his license and began practice the same year at Merrimac, in Taylor County.

In 1919, Dr. Hiestand became Secretary of the Taylor County Board of Health and part-time health officer, an office which he filled until 1950, when a full-time county health department was established.

Dr. Hiestand was elected Vice-President of the K.S.M.A. in 1944, and served two terms as President of the Muldraugh Hill Society. He has held every office of his county society, acting as secretary for a decade.

Dr. Hiestand has been actively engaged in political life, serving for several years as a member of the City Council and is now serving as Mayor of his native city of Campbellsville.

He was Acting Coroner during World War II.

Dr. Hiestand was endorsed for his nomination by the Taylor County Medical Society.

Second, Dr. John E. Kincheloe of Hardinsburg. Dr. Kincheloe was born in Hardinsburg in 1877.

He graduated from the Kentucky School of Medicine in 1899, interned at St. Joseph Infirmary and began his practice in 1899 in Hardinsburg, where he has practiced since.

Dr. Kincheloe is a member of the Breckin-

ridge County Medical Society, the Kentucky State Medical Association and the American Medical Association.

In 1946 over 5,000 people gathered in Hardinsburg to pay tribute to Dr. John Kincheloe by celebrating "Kincheloe Day."

Third, Dr. Cody Harrison Jones of Lynn Grove, Kentucky. Dr. Jones was born March 23, 1884, in Calloway County.

He graduated in 1912 from the University of Louisville, received his license and began practice in 1912 in Hamlin, Calloway County.

In 1914, he began practice in Lynn Grove, Kentucky.

Dr. Jones served as President of the Calloway County Medical Society in 1946 and has always maintained membership in the Kentucky State Medical Association.

Dr. Jones is a veteran of World War I.

The Calloway County Medical Society nominated Dr. Cody H. Jones for the Stovall Award.

Fourth, Dr. Ruben M. Coblin, Frankfort. Dr. Ruben M. Coblin was born in Henry County in 1875.

He graduated from Miami Medical College, Cincinnati, Ohio, in 1897. The same year he began practice at Millsville, a small village about ten miles from Frankfort. After practicing there for six years he did postgraduate work at Polyclinic Medical College, New York.

Settling in Frankfort, Dr. Coblin was elected City Health Officer in 1906 and served in that capacity, with the exception of two years, until 1951.

Dr. Coblin is a member of and has served in every office of the Franklin County Medical Society. He is also a member of the Kentucky State Medical Association, a Fellow of the American Medical Association, and is on the staff of the King's Daughters Hospital in Frankfort.

Dr. Coblin was endorsed for this nomination by the Franklin County Medical Society.

**SPEAKER HOUSTON:** You will now ballot on this award and I ask that the first three tellers serve for this award.

I declare the balloting closed.

Now then, I have in the Distinguished Service Award the following results. There were 95 votes; Dr. E. M. Howard received 20, Dr. Carl Norfleet 21, Dr. John Scott 37, and Dr. W. O. Johnson 17. As per custom, we will drop the last name, the low number name, Dr. Johnson, and we will vote for the second time on the Distinguished Service Award for Dr. E. M. Howard, Dr. Carl Norfleet, and Dr. John Scott. May I ask that the second tellers spread the ballots for this voting.



This is the second balloting on the Distinguished Service Award. Dr. E. M. Howard, Dr. Carl Norfleet, and Dr. John Scott. Are all the ballots in on the second ballot for the E. M. Howard Award? Is so, I declare the balloting closed. We had 97 ballots, 78 for Dr. Lukins, 19 for Dr. Brosheer. Dr. Lukins here obtained a big majority and will be the recipient of the E. M. Howard Award.

I notice in the back of the room we have Dr. Henderson and Dr. Lull. I will ask them to please stand and be recognized. (Applause.)

To save time while we are waiting for the ballots to come in, we will have the report of the Secretary-Editor, Dr. Underwood.

**DR. UNDERWOOD:** Mr. Speaker, distinguished guests, officers, and members of the House of Delegates, and guests:

You have in the folder there the report of the Headquarters Staff which includes my report, the statistical supplementary reports, the report of Mr. Sanford, of Mr. Dixon, Mr. Jones, and also the report of the Advisory Committee.

#### **REPORT OF THE SECRETARY-EDITOR TO THE 1951 SESSION OF HOUSE OF DELEGATES**

With great satisfaction, I report that substantial advances have been made in the improvement of the services of the Headquarters Office. Much progress has been made in the improvement of existing services as well as in the addition of several new services. Our Association is again taking her place among the leading associations of the country.

It is encouraging to see the physicians of Kentucky providing an ever increasing degree of leadership in the field of health and medical care. Physicians have this responsibility, and they are meeting it in a fine way. Today, in Kentucky, the medical profession is winning more and more respect in public as well as in other professional circles.

A perusal of the contents of the envelopes which were given to you will show the scope of the activity of the Council, of the several committees of the Council and of the House of Delegates. You will see in them an indication of the increased activity to which I above referred.

The Council has had placed upon it the actual making of all policy decisions which it has been necessary to make since the last meeting of the House of Delegates. The Head-

quarters Office has been concerned with the co-ordination and the carrying out of the policies which the Council and the House of Delegates have established. New ideas and factual information have been presented to the Council. Every effort has been made to carry out those activities which the Council and the several committees of the Association have directed.

Mr. Joe Sanford, as my Executive Assistant, has been essential for the work outlined above, and for performing the services required of the Headquarters Office in arranging for all phases of the Centennial Meeting.

As Editor of the Journal of the Kentucky State Medical Association, I take pride in reporting the continued progress which has been made in connection with the Journal. Much effort is being exerted now to improve the scientific content of the Journal. Mr. R. F. Dixon as Associate Editor, has been in charge of the Journal. He has worked closely with the Editorial Advisory Committee and the Editorial Consultants. He has had the assistance of Mr. Sanford as the Managing Editor. Mr. Dixon has handled the administrative work connected with the Kentucky Physicians Mutual, Inc., and the Kentucky Rural Medical Scholarship Fund.

It has been a pleasure to serve as one of your delegates to the American Medical Association. I concur in the report which Dr. Hancock will make to you.

The Headquarters Office has a staff which is completely separated from that of the State Department of Health. It has separate quarters and is now operating on a budget which was approved by the Council. The reports of Mr. Sanford and Mr. Dixon are being made separately, as well as the statistical supplement.

I am grateful to Mr. Sanford and to Mr. Dixon for their loyal and efficient services. I am grateful to the officers, the Council and to the several committees of the Association for their many kindnesses during the year. It is a pleasure to serve the physicians of Kentucky. Words are inadequate to express my feeling of gratitude for all the kindnesses and for the sympathetic understanding which has been shown me during the past year. I can assure you they have been most appreciated.

Respectfully submitted,

/s/ Bruce Underwood

Bruce Underwood, Louisville  
Secretary-Editor

**PHYSICIANS WHO HAVE DIED SINCE 1950  
ANNUAL MEETING  
AS OF SEPTEMBER 25, 1951**

Following is the name of the physician, the address and date of death:

Adams, Edward, (Member) Paducah, Nov. 24, 1950  
 Allen, John D., (Member) Louisville, Oct. 15, 1950  
 Allen, M. S., Elizabethtown, Apr. 17, 1951  
 Ashley, Robert G., (Member) Mayfield, Aug. 5, 1951  
 Bailey, T. B., Blaine, Sept. 23, 1950  
 Baker, Samuel R., (Member) Lexington, Jan. 18, 1951  
 Bass, A. L., Louisville, July 18, 1951  
 Blackburn, John H., (Member) Bowling Green, Feb. 17, 1951  
 Blackburn, Maurice A. (Colored) Louisville, March 6, 1951  
 Bloch, Oscar E., (Member) Louisville, June 23, 1951  
 Bromley, A. W., (Member) Louisa, June 18, 1951  
 Bushong, Corinne, (Member) Tompkinsville, Oct. 16, 1950  
 Buttorff, Gordon S., (Member) Louisville, May 16, 1951  
 Calhoun, John D., Millersburg, June, 1951  
 Claypool, John R., Franklin, Dec. 5, 1950  
 Clayton, John M., (Member) West Louisville, April 3, 1951  
 Cox, John L., Campton, June 9, 1951  
 Coy'e, Wm. J., (Member) Louisville, July 3, 1951  
 Davis, A. M., Ashland, Nov. 1950  
 Eddleman, O. A., (Member) Benton, March 8, 1951  
 Edwards, Fidella, (Member) Glasgow, April 5, 1951  
 English, C. C., (Member) Louisville, Feb. 18, 1951  
 Estes, Elmer N., (Member) Lexington, Apr. 14, 1951  
 Evans, John H., Beattyville, Jan. 27, 1951  
 Gaines, Frank M., Carrollton, Oct. 5, 1950  
 Graham, James C., (Member) Greensburg, Feb. 26, 1951  
 Harned, John W., (Member) Hopkinsville, Apr. 22, 1951  
 Hargrove, W. S., Hickory, April 1951  
 Harralson, John H., (Member) Central City, Jan. 27, 1951  
 Hilliard, H. C., Paducah, March 15, 1951  
 Howell, E. W., Oakton, July 30, 1951  
 Kellam, L. R., (Member) Morgantown, Jan. 31, 1951  
 Kidd, O. R., Paducah, Nov. 14, 1950  
 Kieffer, F. L., (Member) Covington, Nov. 5, 1951

King, R. W., Annville, 1950  
 Knight, J. Oliver, (Member) Louisville, June 23, 1951  
 Krieger, W. A., (Member) Newport, July 28, 1951  
 Lanham, L. T., (Member) Mt. Olivet, Feb. 3, 1951  
 McNabb, John W., (Member) Louisa, Feb. 13, 1951  
 Manning, B. M., Falmouth, Feb. 10, 1951  
 Mason, L. Dudley, (Member) Middletown, Oct. 11, 1950  
 Mercer, Herman A., (Member) Louisville, Oct. 3, 1950  
 Merchant, H. A., (Colored) Lexington, 1950  
 Morris, H. T., (Member) Greenup, May 23, 1951  
 Neel, W. V., (Member) Henderson, Jan. 30, 1951  
 Nevins, John T., Harrodsburg, Aug. 1951  
 Nickell, L. G., Sharpsburg, 1950  
 Orr, James A., (Member) Paris, Sept. 24, 1951  
 Paine, Ruby Helen, (Member) Berea, Nov. 3, 1950  
 Pritchett, J. H., (Member) Louisville, Feb. 1, 1951  
 Reising, Kenneth C., (Member) Louisville, Nov. 21, 1950  
 Renaker, J. G., Covington, May 30, 1951  
 Richmond, H. C. T., (Member) Louisville, May 9, 1951  
 Rowe, A. M., Bowling Green, Oct. 2, 1950  
 Ryan, J. M., (Member) Carrollton, Dec. 17, 1950  
 Sanford, M. D., Sadieville, Nov. 19, 1950  
 Schwankhaus, P. H., Louisville, March 13, 1951  
 Shacklette, Junius B., Highland Park, July 16, 1951  
 Siler, L. Steely, Corbin, March 21, 1951  
 Sisk, A. O., (Member) Lexington, Jan. 28, 1951  
 Smith, F. S., (Member) Corbin, April 8, 1951  
 Spradling, S. G., Wellington, Oct. 1950  
 Stephenson, S. F., (Member) Albany, Nov. 22, 1950  
 Threlkell, George W., (Member) Mt. Washington, Aug. 14, 1951  
 Titsworth G. E., (Member) Bandana, Jan. 10, 1951  
 Tucker, Azzie Z., (Colored) Fulton, 1951  
 Tyree, Fred W., Hitchens, May 18, 1951  
 Vallandingham, J. I., (Member) Lexington, Nov. 9, 1950  
 Wallace, Harry Lee, Cadiz, July 13, 1951  
 Warren, J. P., (Member) Lexington, April 3, 1951  
 Weeter, Harry H., (Member) Louisville, Feb. 25, 1951  
 Yates, Earl Carroll, (Member) Lexington, Sept. 1951  
 Youmans, C. E., (Member) Frankfort, May 19, 1951



**NEW MEMBERS SINCE 1950 ANNUAL MEETING AS OF SEPTEMBER 25, 1951**

- Allen  
Davis, Owen L., Scottsville  
Barren  
Engleman, Reinhold, Glasgow  
Howard, Carolyn S., Louisville  
Bell  
Lynch, Everette G., Middlesboro  
Bourbon  
Richardson, Wm. W., Paris  
Boyd  
Connelly, Edw. W., Ashland  
Hoy, Wm. E., Jr., Ashland  
Breathitt  
Turner, Granville V., Jackson  
Campbell-Kenton  
Higgins, Edwin L., Covington  
Carter  
Parrott, Norman A., Grayson  
Christian  
Wells, James H., Hopkinsville  
(Mbr. 40-42-51)  
Wooldridge, Robt. W., Hopkinsville  
Daviess  
Bickel, John E., Owensboro  
Fayette  
Miller, T. Rothrock, Lexington  
Smith, Albert T., Lexington  
Floyd  
Hall, Russell L., Amba  
Loving, Martha A., Lackey  
McKinney, Joseph E., Wheelwright  
Graves  
Hugh, Donald C., Mayfield  
Grayson  
Nichols, Clyde J., Clarkson  
Robertson, W. C., Leitchfield  
Fayette  
Leavell, Ullin W., Jr., Lexington  
Friesen, Carl M., Lexington  
McGowan, John W., Lexington  
Cuthbert, W. H., Lexington  
Green  
Shufflett, Robert L., Greensburg  
Hardin  
Hand, Edward K., Vine Grove  
Harlan  
Davis, David K., Verda  
Gilliam, Lawrence U., Harlan  
Hayes, Hugh H., Twila  
Jones, James B., Verda  
Hart  
Border, C. L., Horse Cave  
Henderson  
Harvey, Clarence C., Henderson  
Smith, W. Landon, Henderson  
Hopkins  
Jones, W. Duane, Ashland  
Trover, Faull S., Madisonville  
Jackson  
Clark, Arch B., McKee
- Jefferson  
Allen, John D., Louisville  
Berger, Israel R., Louisville  
Blodgett, Jean G., Louisville  
Crawford, Paul M., Louisville  
Deyo, Wm. B., (Associate) Louisville  
Dick, Jack, Louisville  
Durham, Wm. C., Louisville  
Gittleman, I. Wilson, Louisville  
Gohman, Joseph T., Louisville  
Havens, Thomas R., Louisville  
(Transfer Mbr.)  
Hawn, Wm. F., Louisville  
Hoekstra, Andrew L., Louisville  
Hofferkamp, August G., Louisville  
Kirtland, Wm. B., Jr., (Assoc.) Oneida  
McClendon, Robt. L., Louisville  
Morgan, Edgar B., Louisville  
Mudgett, Roxie T., Louisville  
O'Neill, Mervin B., Louisville  
Pearce, Charles E., Louisville  
Reed, Edsel S., Louisville  
Reps, Dewey H., Louisville  
Riley, James M., Jr., Louisville  
Ringham, Jarrett, Louisville  
Rosenstein, Abraham S., Louisville  
Ryan, John E., Louisville  
Shein, Melvin, Louisville  
Singerman, Leonard J., Louisville  
Smith, Francis J., Louisville  
Smith, Samuel M., Jr., Louisville  
Spear, Richard C., Louisville  
Steigman, Alex J., Louisville  
Steigall, Thomas G., Louisville  
Walsh, Thomas P., (Mbr. 38-51), Louisville  
Weeter, John C., Louisville  
Williams, Gerald S., Louisville  
Witten, Carroll L., Louisville  
Wallace, Thomas G., Louisville  
Johnson  
Preston, Chas. L., Paintsville  
Knox  
Bower, Daniel L., Barbourville  
Larue  
Crabtree, Carson E., Buffalo  
Laurel  
Wisely, John S., London  
Lawrence  
Carter, Geo. P., Louisa  
Logan  
Gudenkauf, E. B., Lewisburg  
McCracken  
Hunt, Jesse M., Kevil  
Magruder, Margaret B., Paducah  
Orr, C. Pittman, Paducah  
Turner, Walker M., Paducah  
McLean  
Stigall, Benjamin C., Livermore  
Madison  
Hays, Earl T., Jr., Lansing, Mich.  
Metcalf  
Emberton, Lawrence P., Edmonton

## Owen

Ramsey, James T., Owenton  
Pendleton

Hauck, F. C., Falmouth

## Perry

Anderson, Ernest T., Ary  
Boiman, Richard E., Hazard  
Mershon, Jack B., Delphia

## Pike

Heskel, Milton M., Lookout  
Mantooth, Murray K., Virgie

## Todd

Taylor, Wm. L., Guthrie

## Union

Graves, C. B., Morganfield  
Whitley

Clayton, Lewis B., Corbin

## MEMBERSHIP REPORT

(Report of Membership of the Kentucky State Medical Association as of September 25, 1951  
This report does not include Physicians who are ineligible for membership.)

County	Councillor District	Non- Mbrs.	Active Mbrs.	Emeritus Mbrs.	Assoc. Mbrs.	Service Mbrs.	A.M.A. Mbrs.
Adair .....	6	0	6	1	0	0	6
Allen .....	6	1	6	0	0	0	5
Anderson .....	7	1	3	0	0	0	1
Ballard .....	1	3	0	0	0	0	0
Barren .....	6	0	25	0	1	0	22
Bath .....	9	0	4	0	0	0	4
Bell .....	15	13	19	0	0	0	14
Boone .....	8	4	4	0	0	0	2
Bourbon .....	9	0	14	0	0	0	7
Boyd .....	13	12	32	0	0	0	20
Boyle .....	12	2	18	0	0	0	13
Bracken .....	9	2	6	0	0	0	3
Breathitt .....	14	1	3	0	0	0	2
Breckinridge .....	4	1	3	0	0	0	3
Bullitt .....	4	1	0	0	0	0	0
Butler .....	6	0	1	0	0	0	1
Caldwell .....	3	2	7	0	0	0	3
Calloway .....	1	1	14	0	0	0	11
Campbell-Kenton .....	8	48	99	0	0	0	76
Carlisle .....	1	0	4	1	0	0	1
Carroll .....	7	3	5	0	0	0	5
Carter .....	13	4	7	0	0	0	7
Casey .....	12	1	2	0	0	0	2
Christian .....	3	6	33	0	0	0	24
Clark .....	11	3	11	0	0	0	7
Clay .....	15	0	3	0	0	0	1
Clinton .....	12	0	4	0	0	0	4
Crittenden .....	3	1	4	0	0	0	4
Cumberland .....	6	0	5	0	0	0	3
Daviess .....	2	9	46	1	0	0	42
Edmonson .....	6	0	2	0	0	0	2
Elliott .....	13	0	1	0	0	0	1
Estill .....	11	0	6	0	0	0	0
Fayette .....	10	34	158	1	0	1	115
Fleming .....	9	1	7	1	0	0	2
Floyd .....	14	9	21	0	0	0	12
Franklin .....	7	1	17	1	0	0	15
Fulton .....	1	0	10	0	0	0	10
Gallatin .....	7	0	1	0	0	0	1
Garrard .....	12	1	5	0	0	0	5
Grant .....	7	2	5	0	0	0	1
Graves .....	1	4	15	0	0	0	13
Grayson .....	4	0	9	0	0	0	5
Green .....	4	1	3	0	0	0	1



Greenup .....	13	2	8	0	0	0	6
Hancock .....	2	1	0	0	0	0	0
Hardin .....	4	1	16	0	0	0	7
Harlan .....	15	14	38	0	0	0	34
Harrison .....	9	2	10	0	0	0	2
Hart .....	4	0	6	0	0	0	5
Henderson .....	2	4	19	0	0	0	5
Henry .....	7	0	10	0	0	2	7
Hickman .....	1	0	3	0	0	0	2
Hopkins .....	3	2	24	0	1	1	15
Jackson .....	11	1	2	0	0	0	2
Jefferson .....	5	167	593	32	6	10	446
Jessamine .....	10	0	6	0	0	0	1
Johnson .....	14	1	9	2	0	1	9
Knott .....	14	1	2	0	0	0	2
Knox .....	15	0	8	1	0	0	5
Larue .....	4	1	4	0	0	0	1
Laurel .....	15	2	9	0	0	0	8
Lawrence .....	13	2	8	0	0	0	5
Lee .....	11	3	0	0	0	0	0
Leslie .....	15	2	2	0	0	0	0
Letcher .....	14	5	13	0	0	0	4
Lewis .....	13	1	4	0	0	0	3
Lincoln .....	12	0	5	0	0	0	3
Livingston .....	1	3	3	0	0	0	1
Logan .....	6	4	6	0	0	0	5
Lyon .....	3	0	6	0	0	0	2
McCracken .....	1	6	39	0	0	0	36
McCreary .....	12	0	5	0	0	0	4
McLean .....	2	1	4	0	0	0	0
Madison .....	11	4	25	0	0	0	22
Magoffin .....	14	2	2	0	0	0	0
Marion .....	4	3	9	0	0	0	9
Marshall .....	1	0	6	0	0	0	4
Martin .....	14	2	1	0	0	0	0
Mason .....	9	2	12	0	0	0	6
Meade .....	4	2	1	0	0	0	1
Menifee .....	11	0	1	0	0	0	1
Mercer .....	12	0	13	1	0	0	10
Metcalfe .....	6	0	4	0	0	0	2
Monroe .....	6	2	4	0	0	0	4
Montgomery .....	11	3	8	0	0	0	6
Morgan .....	13	2	3	0	0	0	3
Muhlenberg .....	3	0	11	0	0	0	10
Nelson .....	4	0	9	0	0	0	6
Nicholas .....	9	0	4	0	0	0	0
Ohio .....	2	2	3	0	0	0	0
Oldham .....	7	0	4	0	0	0	3
Owen .....	7	0	7	0	0	0	4
Owsley .....	11	0	3	0	0	0	3
Pendleton .....	9	0	5	0	0	0	0
Perry .....	14	7	23	0	0	0	17
Pike .....	14	9	21	0	0	0	17
Powell .....	11	2	0	0	0	0	0
Pulaski .....	12	1	25	0	0	0	20
Robertson .....	9	0	1	0	0	0	0
Rockcastle .....	12	0	5	0	0	0	3
Rowan .....	13	0	5	0	0	0	3
Russell .....	12	1	4	0	0	0	0

Scott .....	9	2	10	1	0	0	0
Shelby .....	7	0	9	0	0	0	8
Simpson .....	6	0	7	0	0	0	0
Spencer .....	4	1	2	0	0	0	1
Taylor .....	4	2	7	1	0	0	7
Todd .....	3	0	7	0	0	0	6
Trigg .....	3	0	4	0	0	0	4
Trimble .....	7	0	1	0	0	0	1
Union .....	2	2	9	0	0	0	6 ..
Warren .....	6	2	25	1	0	2	24
Washington .....	4	1	3	0	0	0	3
Wayne .....	12	1	4	0	0	0	2
Webster .....	2	6	5	0	0	0	3
Whitley .....	15	3	17	0	0	0	12
Wolfe .....	11	1	2	0	0	0	0
Woodford .....	10	2	7	0	0	0	2
		<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
		465	1848	45	8	17	1329

### REPORT OF JOSEPH P. SANFORD, EXECUTIVE ASSISTANT

As the Executive Assistant, I work under the direction and supervision of Bruce Underwood, M. D., the Secretary and General Manager of the Association.

The Headquarters Office is most interested in cooperating with the local County Medical Societies. Every effort is made to keep them properly informed, to assist in the collection of their dues and help in every manner possible to promote their local program. We seek to give publicity to their local activities, and urge each, as is provided in the By-Laws of the Association, to send minutes of each meeting for publication in the Journal.

Working with the Councilors, I have assisted in the promotion of approximately twenty district meetings, which included helping to arrange programs, handling publicity, advance letters, etc. It is respectfully ventured that few members realize the amount of effort and time the Councilors expend or the degree of responsibility carried in discharging their many duties.

Direct supervision of the department of membership records is one of my duties. Despite the considerable number of physicians absorbed by the Armed Forces, our membership is substantially as large this year, the total for 1950 being 1,965, and 1951, 1,918. We have cooperated with President Sam A. Overstreet's strong efforts to increase the number of A.M.A. members among our own number. At this time in 1950 we had 1,198 A.M.A. members, this year we have 1,329. We have worked very closely with the Medical Student Group in promoting both the K.S.M.A. and A.M.A. student memberships.

In recent months, Dr. Underwood has assigned me the title of managing editor of the Journal. In this capacity I work under the

supervision of Mr. Raymond Dixon, the Associate Editor. We are making every effort to keep non-scientific material in the Journal fresh and helpful to you. I assist the Secretary and General Manager in the preparation of the Secretary's Letters. News releases on Association activities to newspapers and radio stations emanate from our office.

During the past year, a number of new programs have made their debut in the Association. Perhaps the most important single event was the first Annual County Society Officers Conference held March 1, when more than 100 of our state and county officers heard some of the leading medical minds in the country discuss the problems of the local county society.

Another new program the Association has undertaken which I have had the pleasure of assisting in is the Rural Health Council, a project of the Rural Health Committee. This committee's program will soon place the Association beside such progressive states as Ohio, Nebraska and West Virginia in this field of service. Much preparation is involved in a venture of this sort to insure success. We are counting heavily on our new Field Secretary in this program.

Our office is working very closely with Kentucky's first statewide participation in the National Diabetic Detection Drive the week of November 11-17. Due to the efforts of this recently activated Diabetic Committee, the Association became the 36th state to bring another new service to the public. We are glad to have the services of Mr. Jones in this endeavor.

The Council recently authorized a postgraduate telephone program. This project will be conducted during the months of February, March and April, with the cooperation of the University of Louisville Medical School. Small local county medical societies will be able to have fresh, live broadcasts right in their reg-



ular meeting quarters and hear top medical talent at a minimum cost.

As Secretary to the McDowell Committee, I assisted in the formation of the McDowell Memorial Foundation, a non-profit corporation that will operate the shrine at Danville, and have carried out the directives of it.

One of our most time-consuming activities grows out of my work as Secretary of the Kentucky Advisory (Procurement) Committee to Selective Service. As Secretary to this Committee, I am in constant touch with the Chairman of the Committee, who instructs and directs me in all that is undertaken. It is necessary to spend much time in gathering information for the Committee, and there is considerable telephoning and correspondence. I went to Washington in January at Selective Service expense to attend a conference with the chairman of the Committee.

Other committees I have actively worked with are the Committee on Emergency Medical Service, which has engaged in civilian defense; the Committee on Medical Economics; the K.S.M.A.-Dental Committee; and the Committee to Train Ambulance Attendants. I have worked with the Legislative Committee, the Committee on Scientific Exhibits and the Committee on Arrangements. I also serve as Secretary to the Professional Relations Committee, a very active group, and have cooperated with the Public Relations Committee.

The Centennial Committee, activated at the Annual Meeting in Owensboro in 1949, has the over-all responsibility of projecting this 100th birthday meeting. I have worked very closely with this committee during the past two years. Time or space does not permit the reporting of a fraction of the activity we have had a part in with respect to the meetings of the big committees and the numerous subcommittees, and the carrying out of their directives. One of my more important responsibilities has been the promotion of the Technical Exhibits, under the direction of the Committee on Technical Exhibits. Due to certain changes in assignment of floor space, we rented an all-time high of 64 spaces in the exhibit hall at the Columbia Auditorium. From this rental, the Association will derive \$5,500.00 more than the maximum realized at the 1947 meeting at a Louisville hotel, and approximately \$1,400 more than the 1950 session.

Additional activities in connection with the Centennial Celebration include working with the subcommittee charged with publishing the Centennial Volume, the subcommittee charged with promoting the special 22-page section in the September 23 issue of the Sunday Courier-Journal dealing with medicine's Centennial, and our own Centennial issue of the Journal.

Uncounted meetings and conferences were held in the development of these features, in addition to the vast volume of work entailed. The subcommittee charged with the historical exhibits did a great amount of work, as did the Committee on Scientific Assembly. Every effort has been made to properly publicize this meeting, not only to the profession in Kentucky and adjoining states, but to interns, residents, medical students and to the public. Other important and time-consuming duties included the getting out of the program booklet, the program leaflet and collecting and processing the reports to the House of Delegates.

I have appreciated and enjoyed the opportunity of attending the Cleveland and Atlantic City meetings of the A.M.A. during the past year. My trips have been profitable to the Association in that I was able to sell space for our own technical exhibits. It was helpful attending these meetings in that I learned much. I attended the National Rural Health Conference in Memphis, and consider it a most worthwhile experience.

I am thankful for the fact that the Headquarters staff has been brought to full strength with the employment of Mr. Raymond M. Jones, as Field Secretary. With this important addition, the days ahead will see our organization growing in usefulness to the Association and the public.

I have greatly enjoyed working with Dr. Underwood, the Council, Dr. Overstreet, other Association officers, Mr. Dixon, and the host of Association committees. I appreciate the tolerance of these individuals and groups of my shortcomings.

I am most grateful to our excellent staff which has worked so faithfully, loyally and efficiently over the past year, and especially for this Centennial Meeting.

Respectfully submitted,

/s/ J. P. Sanford

Joseph P. Sanford, Louisville  
Executive Assistant

#### **REPORT OF R. F. DIXON, ASSISTANT SECRETARY-ASSOCIATE EDITOR**

The undersigned has had the pleasure of serving the Association on a part-time basis as the Assistant Secretary of the Kentucky Physicians Mutual, Inc., as Assistant Secretary of the Rural Kentucky Medical Scholarship Fund, and as Associate Editor of the Journal. All of these duties are carried out under the general supervision of the Secretary-Editor who has delegated the greater part of his duties in these capacities to the Assistant Secretary-Associate Editor.

To report all the activities in which the headquarters office has participated in each of these functions would result in a duplica-

tion of much of the reports from these bodies and hence many are omitted from this report.

**KENTUCKY PHYSICIANS MUTUAL, INC.:** The Assistant Secretary has arranged all meetings of the Board of Directors and meetings of the Executive Committee when called by the President by notifying the members and preparing an agenda. He has kept minutes and forwarded copies to all directors following the meeting. He has carried out instructions and policies agreed upon in the meetings.

It is the responsibility of the Assistant Secretary to obtain signatures of participating physicians. There has been constant effort in this regard. Each non-participating physician has been contacted by correspondence at least twice directly, and also indirectly through the councilors in the various districts. Several editorials have been written for the Journal on this subject. That this approach has been more effective than the indirect method formerly used is shown by the fact that the report to the 1950 Annual Meeting showed only 44 counties in which the majority of physicians were participating with the Plan. As of September 15, 1951, Blue Shield may operate in 104 counties due to cooperation of the physicians in those counties.

In response to popular demand the Board of Directors has made Blue Shield contracts available to individuals without the requirement of group employment. This action has made physician cooperation even more important than it had previously been. Since these contracts can most effectively be sold through newspaper advertising, it is feared that bad public relations for the profession may result when applications from some counties must be rejected because of lack of physician participation.

**RURAL KENTUCKY MEDICAL SCHOLARSHIP FUND:** The Assistant Secretary has been responsible for all activities in connection with the operation of the Fund in which the headquarters office participates. Meetings of the Board of Trustees have been arranged, agendas prepared and minutes kept. All applications for loans have been processed, requiring considerable correspondence. Arrangements are made for each applicant to appear before the Board for personal interviews. After all preliminary details are in order, the fiscal agent is authorized to make loans in the amount granted by the Board or the Executive Committee. A brochure concerning the operation of the Fund was prepared which has proved to be an effective means of furnishing information to applicants and to other interested persons. The annual dinner at the Pendennis Club in honor of the graduates was arranged.

As a basis of approval of locations of graduates in areas in greatest need of a physician, a study was made of the medical care available to the citizens of each county. Using the location of reported births and deaths attended by each physician in the state as an index of the counties in which each physician practices, each physician was "fractionalized" for statistical purposes. Physician-population ratios were calculated and graduates were given freedom of choice in all counties where the ratio exceeded 3,000 persons per physician.

**THE JOURNAL:** The Associate Editor has carried out most of the duties of the Editor including general supervision of all Journal activities. He has been personally responsible for the Editorial and Editorial Comment sections of the Journal under the supervision of the Editor. He has worked closely with, and wishes to express his appreciation to the Advisory Committee to the Editor in efforts to continually improve the content of the Journal and upon all matters of importance that are not covered by existing policy.

The monthly publication of a Journal such as ours is a sizeable undertaking and requires a great deal of effort on the part of all of the employees in the headquarters office. This effort has been systematized and definite duties and responsibilities have been assigned to each employee in writing.

In addition to these specific duties the Assistant Secretary has been assigned other duties by the Secretary and General Manager from time to time and has attended many meetings, including those of the Council and the Legislative Committee.

It has been a pleasure and a challenge to be engaged in these activities of the Association and suggestions from the membership as to ways and means of improving these services will be welcomed.

Respectfully submitted,  
/s/ Raymond F. Dixon  
Raymond F. Dixon  
Assistant Secretary-Associate  
Editor

#### REPORT OF RAYMOND JONES, FIELD SECRETARY

As Field Secretary, I assumed my duties August 1, 1951, working under the supervision of, and with direction and guidance from, the Executive Assistant, Joseph P. Sanford. My duties have been varied and informative.

The first few weeks of my employment were devoted to acquainting myself with the office personnel and procedures—also the organization and operation of the Association.

Other duties delegated me have been to assist Mr. Sanford in arrangements pertaining



to the Centennial Meeting, which involves heavy correspondence, many phone conversations and many personal calls.

The Secretary and Executive Assistant have asked me to assist the Legislative Committee in promoting its 1952 Legislative program.

Another interesting assignment has been to assist the State Diabetic Committee in promoting a statewide Diabetic Detection Drive from November 11-17 inclusive.

I wish to express my sincere appreciation to Dr. Underwood, Mr. Dixon, and especially to Mr. Sanford and the staff for their kind co-operation in assisting me in the eight weeks I have been with the Association. I have learned much and realize there is much to be learned and much to be done in the future toward the promotion of an over-all program.

Respectfully submitted,

/s/ Raymond Jones

Raymond Jones, Anchorage  
Field Secretary

#### REPORT OF EDITORIAL ADVISORY COMMITTEE TO THE 1951 SESSION OF HOUSE OF DELEGATES

As is suggested by its title, the committee has served in an advisory capacity to the Editor of the Journal and to his delegated representatives in all efforts to improve the Journal and in matters which require establishment of policy.

We are glad to report that in our opinion the major changes which were made last year in the cover page and format of the Journal have apparently been well received by the membership, and that the establishment of the Board of Scientific Consultants for the purpose of reviewing papers submitted for publication has resulted in improved scientific content. Methods for standardizing the review of papers are now under consideration and it is hoped that refinement of the system now in use will prove to be beneficial.

It is our impression that the readability of the Journal has been considerably improved and that it is being read more thoroughly.

Respectfully submitted,  
EDITORIAL ADVISORY  
COMMITTEE

/s/ Guy Aud

Guy Aud, Louisville, Chairman  
R. Haynes Barr, Owensboro  
William R. McCormack,  
Bowling Green

In addition to those reports I would like to give a few words of encouragement. It is very encouraging to those of us in the Headquarters Staff to see the Kentucky State Medical Association again taking her place among the

leading associations in this country. It is encouraging for us to see the medical profession of our state assuming an ever more important role in meeting the responsibilities of the medical profession for providing the leadership that is needed in every phase of health and medical care in our state. It is encouraging to see the Council and House of Delegates making all of the policy decisions that are made. It is encouraging to see a separate and distinct staff of headquarters personnel which carries out the mandates handed to them by the Council and the House of Delegates and the various committees of these two bodies.

It is encouraging to see the improvements that have been made and are being made in the Journal. It is encouraging to see the activity that is now taking place in the various committees of the Council and of the House of Delegates and the Association. It is encouraging to see the activity on the part of the officers of the Association. It is encouraging to see that the offices of the Association are no longer honorary positions. They are working positions.

In your folder in addition to all of our reports, I believe you can see some reflection of the activity that has gone on this past year. In addition to all of that you will find a printed copy of the present constitution and by-laws of our Association, and the final report that is in your folder is the Code of Ethics of the American Medical Association. I urge every doctor in Kentucky to read and study the Code of Ethics of the American Medical Association. There isn't any group or profession in the world—save the ministerial—that has a higher code of ethics to live up to. I encourage you to read it and study it and to be familiar with it.

I would close with a word of appreciation for the privilege of having served as a delegate to the American Medical Association, for having had the privilege of serving in all of the different capacities and by being associated with you in those capacities, and then for the privilege of working with some people in Headquarters Office which are as fine, if not finer, than any other group that works for any state association in this country.

**SPEAKER HOUSTON:** I will refer the report of the Secretary to Reference Committee number 1.

I now have the report from the second balloting for the Distinguished Service Award. I have a total of 103 votes, 45 for Dr. John W. Scott, 32 for Dr. Carl Norfleet, and 26 for Dr. E. M. Howard. As the majority has not been reached, I will request the third ballot, leaving off the name of Dr. E. M. Howard. We will vote on the third ballot. The vote will be

between Dr. John W. Scott and Dr. Carl Norfleet. I will ask the tellers to distribute the ballots one more time.

Are all the ballots in? I declare the ballot-ing closed. While we are waiting for the tellers to count, I will call for the report of the treasurer, Dr. Troutman.

#### REPORT OF THE TREASURER TO THE 1951 SESSION OF HOUSE OF DELEGATES

We have examined the annual audit of our Certified Public Accountants and find conditions as represented in this report. The audit is on file for the inspection of any member of the Association who may be interested.

Respectfully submitted,  
/s/ Woodford B. Troutman  
Woodford B. Troutman, Louisville  
Treasurer

July 23, 1951

#### REPORT OF AUDIT

We submit herewith report of our audit of the books and records of your Secretary, Dr.

Bruce Underwood, and your Treasurer, Dr. Woodford B. Troutman, for the ten months ending June 30, 1951. Your Association has authorized to change to a June 30 fiscal year.

The assets were verified in the manner and to the extent stated in the schedules and comments in this report. Cash receipts and disbursements were checked by us to the extent necessary to satisfy ourselves as to the accuracy and integrity of the records.

Subject to the comments above, and in the various schedules in this report, we hereby certify that, in our opinion, the attached statements and schedules fairly present the assets of the Kentucky State Medical Association at June 30, 1951, and its receipts and disbursements for the period ending that date, as reflected by the records.

Respectfully submitted,

(Signed)

Christen, Brown, McCroskey and  
Rufer, Certified Public Account-  
ants

#### STATEMENT OF ASSETS

June 30, 1951

##### CASH:

Cash in Banks, Checking Accounts.....	\$ 7,753.11	
Cash in Banks, Savings Accounts.....	25,486.22	\$ 33,239.33

##### INVESTMENTS:

United States Government Bonds—At Cost— (Redemption Value \$31,188.04) .....	32,231.00	
Louisville Title Mortgage Co. Stock At Cost—(Market Value \$922.50) .....	755.52	32,986.52
Accounts Receivable - Advertising .....		957.22
Total Current Assets .....		67,183.07
McDowell Property - At Appraised Value.....	25,000.00	
McDowell Home - Furnishings at Appraised Value .....	5,000.00	30,000.00
Library .....	480.00	
Office Equipment - At Cost.....	\$4,908.41	
Less Reserve for Depreciation.....	474.98	4,433.43
TOTAL ASSETS .....		\$102,096.50

#### STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

TEN MONTHS PERIOD ENDING JUNE 30, 1951

	Checking Accounts	Savings Accounts	Total
Balances in Banks September 1, 1950 .....	\$ 4,437.89	\$4,951.07	\$ 9,388.96



## RECEIPTS:

Association Dues			
(Schedule A) .....	27,574.00		27,574.00
Journal of the Kentucky State Medical Assn.			
(Schedule B) .....	10,477.22		10,477.22
Exhibit Space—Louisville Meeting - 1950.....	2,905.00		*2,905.00
Exhibit Space - Louisville Meeting - 1951.....	4,832.50		4,832.50
Repayment of Advance to Kentucky			
Physicians Mutual, Inc. ....	20,200.00	4,800.00	25,000.00
Interest on Advance to Kentucky			
Physicians Mutual, Inc. ....	633.34		633.34
Dividends and Interest on Investments and			
Savings Accounts .....		740.13	740.13
Reimbursement for Services and Expenses,			
Etc., by American Medical Association			
and Kentucky Physicians Mutual, Inc.....	1,194.51		1,194.51
McDowell Fund Contributions			
(Schedule C) .....	5,199.60		5,199.60
American Medical Association Dues			
(See Disbursements) .....	37,800.00		37,800.00
Transfer from Savings Account.....	9,000.00	(9,000.00)	
Transfers to Savings Accounts .....	(24,000.00)	24,000.00	
Total Receipts and Balances in Bank.....	100,254.06	25,491.20	125,745.25

## DISBURSEMENTS:

Kentucky State Medical Association			
(Schedule D) .....	38,079.44		38,079.44
Journal of the Kentucky State Medical Assn.			
(Schedule E) .....	11,874.31		11,874.31
McDowell Fund—			
(Schedule F) .....	4,719.20		4,719.20
American Medical Association Dues Remitted.....	37,800.00		37,800.00
State Meeting Expense (Telephone and			
Telegram, Etc.) (1951 Meeting) .....	28.00		28.00
State Tax on Savings Deposit .....		4.98	4.98
Total Disbursements .....	\$92,500.95	\$ 4.98	\$92,505.93

BALANCES IN BANKS, JUNE 30, 1951.....	\$ 7,753.00	\$25,486.22	\$33,239.33
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Consisting of:

Association and Journal Checking Account.....			\$ 5,991.18
Association and Journal Savings Accounts.....			25,486.22

## MCDOWELL FUND:

Furniture Account .....	\$ 1,105.55		
Furniture Account - Woman's Auxiliary to			
Jefferson County Medical Society.....	115.25		
Furniture Account - Doctor's Office.....	502.50		
Repairs and Supplies Account .....	33.05		
Petty Cash Fund .....	5.58		1,761.93

TOTAL .....			\$33,239.33
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\*Additional income for 1950 meeting was reported in fiscal year ending August 31, 1950.

**SCHEDULE A—Association Dues:**

	Membership		Rate	Amount	
	1950	1951			
Regular Members:					
Current Year Dues .....		1,802	\$15.00	\$27,030.00	
Current Year Dues .....		8	5.00	40.00	\$27,070.00
1950 Dues Paid in 1951.....	18		15.00	270.00	
1950 Dues Paid in 1951.....	18		7.50	135.00	
1950 Dues Paid in 1951.....	2		5.00	10.00	
1950 Dues Paid in 1951.....	4		2.50	10.00	425.00
Total Regular Membership...					27,495.00
Student Members .....	35	44	1.00		79.00
TOTALS .....	77	1,854			\$27,574.00

**SCHEDULE B—Journal of the Kentucky State Medical Association Receipts:**

Cooperative Advertising .....	\$ 8,150.48
Cooperative Profit Distribution .....	590.45
Local Advertising .....	1,545.54
Subscriptions and Sales .....	190.75
TOTAL .....	\$10,477.22

**SCHEDULE C—McDowell Fund Contributions:**

	Number of Contributors	Amount
Contributions:		
\$ 1.00—\$ 10.00 .....	1	\$ 5.00
10.00— 25.00 .....	1	10.00
25.00— 50.00 .....	35	875.00
50.00— 100.00 .....	2	100.00
100.00— 500.00 .....	7	972.35
\$1,000.00 and over .....	3	3,232.25
Total Contributions .....		5,194.60
Sale of Pictures, Etc. ....		5.00
TOTAL .....		\$5,199.60

**SCHEDULE D—Disbursements of Kentucky State Medical Association:**

Secretary and General Manager's Salary.....	\$ 2,500.00
Executive Assistant's Salary .....	6,250.00
Executive Assistant's Sundry Expenses .....	595.28
Assistant Secretary's Salary .....	2,500.00
Field Secretary's Salary .....	2,250.00
Field Secretary's Sundry Expenses .....	564.82
Other Office Salaries .....	9,702.92
Medico-Legal Committee—Salary and Fee .....	500.00
Professional Relations Committee—Salary .....	250.00
Expenses of Delegates to A.M.A. Meetings.....	286.18
Officers, Councilors and Committee Expenses.....	243.21
Pay Roll Taxes .....	295.56
City Occupational Tax Withheld from Employees during Prior Year, Disbursed during Current Period .....	49.20
Stationery including Paper for Photostats .....	654.33
Telephone, Telegraph and Express .....	547.99
Postage .....	1,618.14



Office Supplies .....	183.10
Office Equipment .....	2,062.41
Repairs to Office Equipment .....	121.35
Association Membership Cards .....	33.75
Addressograph and Multigraph Expense .....	24.85
Miscellaneous Operating Expense .....	110.80
Books, Etc. ....	76.70
Miscellaneous Expense .....	204.40
Louisville Meeting Expense (Includes \$424.22 for Equipment) (1950 Meeting) ....	5,168.27
Dues .....	30.00
Auditing Expense .....	150.00
Physicians' Directories .....	410.00
Binding Journals .....	30.75
Insurance on Office Equipment .....	39.12
Educational Campaign Committee Expense.....	610.73
State Tax on Bank Deposit .....	9.58
<b>TOTAL .....</b>	<b>\$ 38,079.44</b>

**SCHEDULE E—Disbursements of Journal of the Kentucky State Medical Association:**

Printing Expense .....	\$ 9,428.00
Color Advertising, Copper Halftones, Etc. ....	1,399.05
Express and Freight .....	41.55
Telephone and Telegraph .....	50.47
Postage .....	300.00
Envelopes .....	497.83
Associate Editor Sundry Expense .....	157.41
<b>TOTAL .....</b>	<b>\$ 11,874.31</b>

**SCHEDULE F—McDowell Fund Disbursements:**

## Furniture Account:

Furniture .....	\$ 1,880.40	
Supplies and Printing .....	101.25	
Sundry Expenses .....	421.15	
Articles of Incorporation and Recording.....	107.00	\$ 2,515.80
<b>Furnishings for Home .....</b>		<b>1,117.00</b>
Furniture Account—Doctor's Office:		
Furniture .....		122.50
Repairs and Supplies Account:		
Supplies and Services .....	699.94	
Equipment (Oil Burner) .....	263.96	963.90
<b>TOTAL .....</b>		<b>\$ 4,719.20</b>

**CASH:**

	Balance Per Bank	Less Out- standing Checks	Balance Per Books
Checking Accounts:			
Bullitt County Bank, Shepherdsville, Ky.			
Treasurer's Account .....	\$13,110.72	\$ 5,363.19	\$ 7,747.53
Lincoln Bank & Trust Co. ....			
Association Account .....	1,450.00	1,450.00	
Farmers National Bank, Danville, Ky.			
McDowell Fund—Petty Cash Fund .....	5.58		5.58
<b>TOTALS .....</b>	<b>\$14,566.30</b>	<b>\$ 6,813.19</b>	<b>\$ 7,753.11</b>

## Savings Accounts:

Bullitt County Bank, Shepherdsville, Ky.

Treasurer's Account .....	9,472.23
Lincoln Bank & Trust Co. ....	9,008.25
First National Bank .....	7,005.74

TOTAL ..... \$33,239.33

Cash in banks subject to check was reconciled with the balances reported to us by the bank. Cash in savings accounts were verified by correspondence with the banks.

The above includes cash of the McDowell Fund amounting to \$1,761.93. It is included in the checking account and McDowell Petty Cash Fund. In May 1951, the McDowell Memorial Foundation was incorporated, but there have been only organizational activities to the time this report was written. We were informed when actual operations begin, the \$1,761.93 and any other funds held for the account of the Foundation will be remitted to it after proper authorization. Statement of McDowell Fund, on Page 10 of this report, sets forth the details of this Fund.

## INVESTMENTS:

	Maturity Value	Present Redemption or Market Value	Cost
U. S. Savings Bonds, Series F. ....	\$ 650.00	\$ 539.04	\$ 481.00
U. S. Savings Bonds, Series G. ....	31,000.00	29,639.00	31,000.00
TOTALS .....	\$31,650.00	\$30,188.04	\$31,481.00
U. S. Savings Bond, Series D— Matured—Out for Collection .....	1,000.00	1,000.00	750.00
TOTALS .....	\$32,650.00	\$31,188.04	\$32,231.00
82 Shares Louisville Title Mortgage Co. Common Stock .....		922.50	755.52
TOTALS .....		\$32,110.54	\$32,986.52

The above investments are stated at cost.

These investments were held on safekeeping with the Bullitt County Bank, Shepherdsville, Ky., and were verified by correspondence with that bank.

Interest received on bonds amounted to \$675.00, and dividends on the stock was \$49.20.

## ACCOUNTS RECEIVABLE—ADVERTISING:

Journal Advertising Bureau ..... \$820.71 (A)

## Other Advertising Accounts:

Irvin Cobb Resort .....	\$ 18.00 (A)	
Coca Cola Co. ....	16.80	
Creditors Protective Bureau .....	36.00 (B)	
C. O. Miller .....	2.50	
Norton Infirmary .....	15.81	
Dr. Frank Pirkey .....	25.50	
Dr. W. H. Schien .....	1.50 (C)	
W. D. Mattingly .....	20.40 (D)	136.51
Total .....		\$957.22

A—Paid in July 1951

C—1948 Advertising

B—1946 Advertising

D—1949 Advertising (in Dispute)

The Journal Advertising Bureau accounts represent the amount due for advertising in June in the Journal of the Kentucky State Medical Association.

Other advertising accounts are for monthly advertising in the Journal.



**McDOWELL PROPERTY AND FURNISHINGS:**

McDowell Property—At Appraised Value .....	\$25,000.00
Furnishings—At Appraised Value .....	5,000.00
Total .....	\$30,000.00

The Association reacquired the McDowell Property, Danville, Ky., from the Commonwealth of Kentucky, Division of State Parks, on June 6, 1949, at no cost. Before deeding it to the Commonwealth of Kentucky in 1935 for use as a state park, the Association had purchased it for \$13,500.00. Other comments concerning this property were set forth in prior audit reports.

**LIBRARY AND OFFICE EQUIPMENT:**

<b>Library:</b>	<b>Cost</b>	<b>Reserve for Depreciation</b>	<b>Depreciated Value</b>
48 Bound Volumes Journal of the State Medical Association .....	4,908.41		4,433.43
Office Equipment .....	4,908.41	\$ 474.98	4,433.43
<b>TOTALS .....</b>	<b>\$ 5,388.41</b>	<b>\$ 474.98</b>	<b>\$ 4,913.43</b>

Office equipment purchases of \$2,486.63 during the period were verified with invoices.

It is the practice of the Association to reduce the cost of office equipment 10% each year for depreciation. When an item is fully depreciated, it is eliminated from the account and carried on a list of fully depreciated equipment.

No depreciation is taken on equipment in the year of purchase. Cost of office equipment was reduced \$201.78 during the ten-month period.

**STATEMENT OF McDOWELL FUND:****Furniture Account—Regular:**

Balance, Sept. 1, 1950 .....		\$ 279.00	
Contributions .....	\$2,967.35		
Transfer of Cost of Desk .....			
Disbursement for Doctor's Office .....	375.00	3,342.35	
<b>TOTAL .....</b>		<b>\$3,621.35</b>	
<b>Disbursements:</b>			
Furnishings for Home .....	1,886.40		
Supplies and Printing .....	101.25		
Traveling Expenses .....	421.15		
Articles of Incorporation .....	107.00	2,515.80	
Balance, June 30, 1951 .....			\$1,105.55

**Furniture Account—Woman's Auxiliary to Jefferson County Medical Society:**

Balance, Sept. 1, 1950 .....	0		
Contribution from Jefferson County Auxiliary..		1,232.25	
<b>TOTAL .....</b>		<b>\$1,232.25</b>	
<b>Disbursements:</b>			
Furnishings for Bed Room .....		1,117.00	
Balance, June 30, 1951 .....			115.25

**Furniture Account—Doctor's Office:**

Balance, Sept. 1, 1950 .....	0		
Contribution from Dr. E. L. Henderson.....		1,000.00	
<b>TOTAL .....</b>		<b>\$1,000.00</b>	

## Transfer from Regular Furniture Account—

Cost of Desk Considered Disbursement for			
Doctor's Office .....	375.00		
Furniture for Office .....	122.50	497.50	502.50

**Repairs and Supplies Account:**

Balance, Sept. 1, 1950 .....	802.53
Petty Cash Fund, Sept. 1, 1950 .....	200.00

TOTAL ..... \$1,002.53

**Disbursements:**

Supplies and Services .....	699.94		
Equipment .....	263.96	963.90	38.63

Balance in Fund, June 30, 1951 ..... \$1,761.93

**BLANKET POSITION BOND COVERAGE**

All employees (excluding the President and three Vice-Presidents)—Each \$10,000.00.

This bond was inspected by us, and was further verified by correspondence with the local agent of the bonding company.

**INSURANCE COVERAGE**

Building—McDowell House—West Side South Second Street, Danville, Ky.:

Fire and Extended Coverage—90% Co-insurance ..... \$25,000.00

Contents—McDowell House:

Fire and Extended Coverage ..... 5,000.00

Office Furniture and Equipment

620 S. Third St., Louisville, Ky.:

Fire Only ..... 4,000.00

I will refer the Treasurer's report to Reference Committee number 1.

I now have a tally on the J. Watts Stovall Award of a total of 103 votes, Dr. Heistand 19, Dr. Jones 14, Dr. Kincheloe 32, and Dr. Coblin 38. We do not have a majority, so I will have to ask for another tally. Leave out the name of Dr. Jones.

Are all of the ballots in? The final ballot on Distinguished Service Award, I have a total of 109 votes. I have 58 votes for Dr. Norfleet and 51 votes for Dr. Scott. Dr. Norfleet will be our recipient of the Distinguished Service Award.

While we are waiting for the tally to be counted on the J. Watts Stovall Award, I will ask for the report of the council for the various districts. Dr. Pace of Paducah.

DR. PACE: The committee report has been filed.

# REPORT OF THE FIRST COUNCILOR DISTRICT TO THE 1951 SESSION OF HOUSE OF DELEGATES

The First District has been confronted, within the last year, by the unprecedented expansion produced by the starting of the greatest atomic energy producing plant on the earth.

Two huge steam generating plants are now under construction in this area to furnish energy to operate this plant. When these power plants are finished, and with the energy produced by Gilbertsville Dam, more energy will be produced in our district than in any other place on earth.

Before the announcement of the Atomic Energy Commission's selection of our district as a location for its main processing area, our industrial expansion at Calvert City and all of our surrounding communities had produced many problems. This increasing industry, in addition to the atomic plant, has and is producing medical health problems here, in the nation's most important emergency area, that are unparalleled.

At the present date, we can only guess from a medical and health standpoint how great the impact of this vast expansion in population will be on our health departments, hospitals, nursing and medical personnel.

We have had an influx of physicians into the First District because of the nationwide publicity given this project. In our opinion, we are able to take care of the needs of the people. We are still critically short of nurses but some are coming into our communities.



Our hospitals over the entire district are operating beyond normal capacity because of the vastly increased population. This produces an increased strain on the hospital personnel, but all of the hospitals continue to give care as well as ever.

One new hospital has been opened in the First District—the Clinton-Hickman County Hospital, at Clinton, Kentucky. It was built by community and Federal funds. It is finely equipped and run and would be a credit to an urban community of any size.

The West Kentucky Baptist Hospital in Paducah, 175-bed capacity, now has walls finished and is to be rushed through to completion.

The City of Paducah has authorized the sale of bonds—the funds secured in this way to be used with funds furnished by the Federal Government to build a six-story addition to Riverside Hospital, which will greatly increase the capacity of the municipally-owned institution. Construction of this addition will be started as soon as architects and hospital consultants complete the plans. It is believed that this addition to Riverside and the completion of the West Kentucky Baptist Hospital, along with the 100 beds now available in the Illinois Central Hospital and the fine hospitals in Fulton, Mayfield, Clinton, Murray and surrounding towns, will furnish adequate hospital care in the entire district for several years.

County society meetings have been well attended and excellent programs furnished to the physicians. Three councilor district meetings were held during the year. One was held at Fulton, one at Mayfield, and another at Paducah with outstanding guest speakers and large attendance.

Your councilor believes that in this time of crisis in our district the medical profession is furnishing all of the people the fine professional care they have traditionally had here in the past. They will not let their communities down.

Respectfully submitted,

/s/ J. Vernon Pace

J. Vernon Pace, Paducah  
Councilor, First District

**SPEAKER HUSTON:** Dr. Barr of Owensboro.

**DR. BARR:** Mr. Speaker, the report has been rendered. It has been mimeographed and is included in the file which has been given to each delegate.

#### **REPORT OF THE SECOND COUNCILOR DISTRICT TO THE 1951 SESSION OF HOUSE OF DELEGATES**

The President and House of Delegates, Kentucky State Medical Association.

Submitted, herewith, is the annual report of

the Second Councilor District, comprised of Daviess, Hancock, Henderson, McLean, Ohio, Union and Webster Counties.

The District contains 111 physicians, an increase of 2 over the number in 1950. These doctors are distributed as follows:

	1950	1951
Daviess .....	56	55
Hancock .....	1	1
Henderson .....	22	23
McLean .....	4	5
Ohio .....	4	5
Union .....	11	11
Webster .....	11	11
	—	—
Total .....	109	111

In only one county in the district, Hancock, is there an acute shortage of medical care as the one physician listed in that county is 74 years of age.

Daviess and Henderson Counties have very active county societies with scientific programs of the highest quality. Union and Webster have a joint society in which the dentists participate. McLean and Ohio counties each maintain their autonomy with a skeleton county organization and collect and remit their own dues. However, they have no regular meetings and no scientific programs and are regular attendants at the meetings of the Daviess County Society. Hancock, of course, has no organization whatever.

The District Meeting, a joint affair with the Second District Woman's Auxiliary, was held in Owensboro in late March. The State President, the Secretary and General Manager, the Executive Assistant Secretary and the President-Elect of the State Woman's Auxiliary were our guests. The scientific program was presented by Dr. Ephraim Roseman of Louisville, Kentucky, who spoke on Epilepsy. Dr. Walter L. O'Nan of Henderson presided.

There are four hospitals with a total of 370 beds in the District. These are distributed as follows:

Owensboro 2 hospitals, 65 and 190 beds.

Henderson 1 hospital, 80 beds.

Morganfield 1 hospital, 35 beds.

Hancock, McLean and Ohio counties have no hospitals but are within a few minutes drive of the Owensboro hospitals.

All counties in the district have a county health department. Daviess, McLean and Ohio have full-time health officers, Webster has a part-time health officer while Henderson, Union and Hancock have health administrators. Union and Webster have a new Health Center.

As in most parts of the country there is a moderate shortage of graduate nurses in this

district. Every effort is being made to relieve this situation by nurse recruitment on the part of county medical societies and members of the one Woman's Auxiliary in the district, that in Daviess County, with 49 members. This Auxiliary has a nurses loan fund from which student nurses may borrow funds to defray their expenses at the school of nursing at Murray State College.

Respectfully submitted,  
/s/ R. Haynes Barr  
R. Haynes Barr, Owensboro  
Councilor

**SPEAKER HOUSTON:** Dr. Barr's report will be referred to the Reference Committee number 1. Third District, Dr. Clardy of Hopkinsville.

**DR. CLARDY:** The Councilor's report for the Third District has been submitted.

**SPEAKER HOUSTON:** It has been submitted and referred to Reference Committee number 1.

#### REPORT OF THIRD COUNCILOR DISTRICT TO THE 1951 SESSION OF HOUSE OF DELEGATES

The new Third Councilor District came into existence by action of the House of Delegates at the 1950 meeting of the Kentucky State Medical Association. It is composed of Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd and Trigg Counties.

The following tables give pertinent data which is of concern to the medical profession.

Counties of 3rd District	Popu- lation	Hosp. Drs.	Hosp. Beds	Full Time Hlth Dept.	Full Time Hlth Ofcr.	Blue Cross Blue Shield Parti- cipation	Org. Med. Soc.	Cancer Clin- ics	Civil Defense Defense ization
Caldwell	14,499	8	507	Yes		Yes	Yes		
Christian	36,126	33	125	Yes	Yes	Yes	Yes	Yes	Yes
Crittenden	12,115	5	25	Yes		Yes	Yes		
Hopkins	37,789	26	75	Yes	Yes	Yes	Yes		
Lyon	9,067	5	25	Yes		Yes	Yes		
Muhlenberg	37,554	11	70	Yes	Yes	Yes	Yes	Yes	
Todd	14,234	7	0	Yes		Yes	Yes		
Trigg	12,784	4	20	Yes		Yes	Yes		

County	Total M.D.'s	Total No. Pd. Mbrs. 1949	Total No. Pd. Mbrs. 1950	Mbrs. 1951 No. Pd. as of 8/22/51	A.M.A. Dues No. Pd. as of 8/22/51
Caldwell	9	9	8	7	3
Christian	39	38	35	33	24
Crittenden	5	3	4	4	4
Hopkins	28	24	24	25	15
Lyon	6	6	6	6	2
Muhlenberg	11	14	16	11	10
Todd	7	6	6	7	6
Trigg	4	3	3	4	4

The Third District cooperated with the K.S.M.A. Committee on Emergency Medical Service and sponsored a meeting at the Western State Hospital May 29. The program was sponsored by the Emergency Medical Service Committee and the State Civilian Defense Organization, and dealt with the treatment of atomic illnesses.

An excellent program and convocation was enjoyed by the doctors, their wives, hospital administrators and invited guests at Hopkinsville, on August 28. Invitations went to twenty-five Western Kentucky counties. The pro-

gram concerned Civil Defense and Hospital facilities and was presented by Dr. John W. Cronin, Washington, D. C., Dr. Francis Weber, Cleveland, Ohio, Dr. Bruce Underwood, Louisville, Kentucky, and Dr. Haynes Barr, Owensboro, Kentucky. This delightful occasion was made possible through the efforts and generosity of Dr. J. G. Gaither, Hopkinsville, who is greatly interested in the hospital program.

Respectfully submitted,  
/s/ Delmas M. Clardy  
Delmas M. Clardy, M. D.  
Councilor, Third District



**SPEAKER HOUSTON:** Dr. Greenwell, Fourth District.

**DR. GREENWELL:** The report has been filed.

**REPORT OF THE FOURTH COUNCILOR  
DISTRICT TO THE  
1951 SESSION OF HOUSE OF DELEGATES**

Since the reorganization of the councilor districts, four more counties have been added to my district, making a total of thirteen in all. We have a total of 89 doctors in this district; 72 of which have paid their annual dues. We have 17 non-members; 48 have paid their A. M. A. dues for 1951.

Most of the counties have organized medical societies and meet regularly each month.

We have three hospitals in my district, one at Campbellsville, one at Lebanon and one at Bardstown. These hospitals are doing good work and running at full capacity. As these hospitals are located in rural counties, we find they are a great help to doctors in the community in which they are located.

I had my councilor meeting in Bardstown in June with about fifty doctors in attendance. Dr. Sam Overstreet, our president, and a number of doctors from Louisville, also Dr. C. C. Howard and two other doctors from Glasgow, were present.

Respectfully submitted,  
/s/ J. I. Greenwell  
J. I. Greenwell, New Haven  
Councilor, Fourth District

**SPEAKER HOUSTON:** The report has been filed, and is referred to Reference Committee number 1. The Fifth District, Dr. Slucher.

**DR. SLUCHER:** The report of the Fifth District has been filed.

**REPORT OF THE FIFTH COUNCILOR  
DISTRICT TO THE  
1951 SESSION OF HOUSE OF DELEGATES**

Since the re-districting last year, the Fifth Councilor District comprises only Jefferson County which has 594 paid members to county and state societies and 445 members paid to A. M. A.

Since the physicians in Louisville and Jefferson County have a monthly county medical society meeting and many other medical and compulsory hospital staff meetings throughout the year, it was deemed unwise to have a special so-called district meeting.

We still have a shortage of hospital beds in Louisville, but more building programs are

on the way. We have many young physicians opening offices here, but the population seems to increase fast enough to keep them all busy. Local Jefferson County committees are still hard at work to establish good local public relations.

Many of us in Jefferson County can see an urgent need for an increase in the state dues, and we hope the House of Delegates will see favorably to vote such an increase.

Much time and effort has been spent by the various members of the Centennial Committees, and I believe the physicians of Kentucky certainly owe them a vote of thanks.

Respectfully submitted  
/s/ R. R. Slucher  
R. R. Slucher, Buechel  
Councilor, Fifth District

**SPEAKER HOUSTON:** It has been filed, referred to Reference Committee number 1. Sixth District, Dr. Howard.

**DR. HOWARD:** It has been filed with the Secretary.

**REPORT OF THE SIXTH COUNCILOR  
DISTRICT TO THE  
1951 SESSION OF HOUSE OF DELEGATES**

I beg to report to you the condition of the Sixth Councilor District. The people are well cared for medically in this district. The doctors are all very active and striving to improve the service to the people. The hospital situation of the district is improving greatly. There is a new hospital in operation at Russellville this year, one under construction at Scottsville, a new addition at the Bowling Green Hospital and also the T. J. Samson Hospital here in Glasgow.

Blue Cross and Blue Shield have sold very well indeed all over the district and are improving. The service can be extended wonderfully with everyone cooperating.

Public health has been fair, not as good as we would like to see it. I feel definitely it is because of lack of funds and of enough medical and civic interest in this great service to the people.

This year brings to a close my service as councilor for this district. I have served in this capacity for many years and I am deeply grateful. This is my last year, and I feel that the rotation of councilor is very necessary as younger men should be growing up in the Council. The Kentucky State Medical Association has been very kind and considerate to me during my forty years of medicine.

This I humbly appreciate and will always be ready to assist them in any way I can.

Respectfully submitted,  
/s/ C. C. Howard  
C. C. Howard, Glasgow  
Councilor, Sixth District

**SPEAKER HOUSTON:** I will refer Dr. Howard's report to Reference Committee number 1. The Seventh District, Dr. Baughman of Frankfort.

**DR. BAUGHMAN:** Mr. Speaker, my report has been made and the copy is in the folder in the hands of each delegate.

#### REPORT OF THE SEVENTH COUNCILOR DISTRICT TO THE 1951 SESSION OF HOUSE OF DELEGATES

This is a new district, with a new councilor, having been organized subsequent to the resolution passed by the House of Delegates at Owensboro in 1949, to reorganize the districts in the Association. It is composed of ten counties, and contains 60 physicians, three of whom are not in active practice. Counties and distribution of doctors are shown in the following table.

County	Number of Physicians	Population
Anderson	5	8,984
Carroll	5	8,517
Franklin	17	25,933
Gallatin	1	3,969
Grant	4	9,809
Henry	10	11,394
Oldham	5	11,018
Owen	5	9,755
Shelby	7	17,912
Trimble	1	5,148
Total	60	112,439

Three young physicians who were in very active work have entered the military service in the past year. They are: Drs. Charles O. Bruce, Jr., New Castle, Robert L. Houston, Jr., Eminence, and Reginald J. Phillips, Jr., Owenton. We sincerely hope it will not be necessary to lose more, for this district, like most others, is in dire need of doctors.

Every county or group of counties has an organized society with officers and a delegate duly elected. The councilor has visited every society which has regular meetings and programs at least once in the past year and has seen every physician in the district. It is a source of satisfaction to the councilor that every county in the district is signed up as participating in the Kentucky Physicians Mutual, Inc. In many of the counties well organized campaigns have been conducted for the

sale of Blue Cross and Blue Shield contracts, and these have met with a splendid response.

One new hospital was opened in the past year—the Owen County Memorial Hospital at Owenton. On Decoration Day the councilor attended the opening of this splendid, modern, well-equipped hospital of 20 beds. It will be of great service to the people of Owen and surrounding counties. There is a great interest in building an addition to the hospitals in Frankfort and in Shelbyville. General hospitals in the district are as follows:

King's Daughters — Frankfort  
King's Daughters — Shelbyville  
Owen County Memorial — Owenton  
Mallory Taylor Memorial — LaGrange  
Pewee Valley Sanitarium — Pewee Valley

Of the 60 physicians in this district, 59 are paid-up members of the Kentucky State Medical Association and 46 are paid-up members of the American Medical Association. One physician has died in the past year, C. E. Youmans, M. D., who was, for many years, superintendent of the Kentucky Training Home at Frankfort and formerly a practicing physician in Frankfort. He was a conscientious and ethical physician, a steadfast friend and a Christian gentleman. He will be sorely missed in Franklin County.

The councilor has endeavored to keep foremost in the minds of the physicians of the district (1) public relations, (2) the fight against socialized medicine, and (3) voluntary prepayment insurance plans, particularly the Kentucky Physicians Mutual, Inc. (Blue Shield). He has striven for an organization of doctors, united in purpose, to be a more effective group. In general, the public relations in the district are good. We have the respect and confidence of our people. We must supply the necessary leadership. As in other parts of the state, our people complain of inability to obtain a doctor at night, on holidays and even for routine daytime house calls. The fault is two-fold, our carelessness and a lack of sufficient physicians.

The annual meeting of the district was held in Frankfort June 29, 1951, and was attended by 78 physicians and their wives. Three scientific papers were presented after dinner, all by physicians practicing in the district. It is our present intent to have no guest speakers, with all papers being presented by doctors in the district who might be reluctant to present a paper before a larger medical group. We believe this is in the best interest of our physicians. We will change this policy if our doctors wish. Our first meeting was most enthusiastic and encouraging. We shall continue to stimulate interest in the annual meeting.



We are grateful for the invaluable help of the Secretary and the Assistant Secretary of the Kentucky State Medical Association.

Respectfully submitted,  
/s/ Branham B. Baughman  
Branham B. Baughman, Frankfort  
Councilor, Seventh District

**SPEAKER HOUSTON:** Dr. Baughman's report is referred to Reference Committee number 1. Eighth District, Dr. Mersch of Covington.

**DR. MERSCH:** The report has been filed.

**REPORT OF EIGHTH COUNCILOR  
DISTRICT TO THE  
1951 SESSION OF HOUSE OF DELEGATES**

This district is composed of Campbell, Kenton and Boone Counties. There is an active Medical Society in Kenton and Campbell Counties. Boone County does not have a Medical Society, but several of the practicing physicians attend the meetings of the Campbell-Kenton Society. Monthly meetings are held at which time scientific papers are presented.

As in most counties, there exists a shortage of physicians in these three counties. There are a large number of old physicians who are retired or semi-retired.

The medical facilities in this district are excellent. The two major hospitals, St. Elizabeth and Booth Memorial, are well staffed and equipped for all types of patients. Wards for psychiatric cases have been opened in the past year at Booth Memorial Hospital and in the near future a psychiatric ward and a contagious unit will be opened at St. Elizabeth Hospital.

There have been several attempts made in the past several years to combine the Health Departments of Covington and Kenton County, and also to combine the Newport City and Campbell County Health Departments. At this time, no definite progress has been made along these lines. It is hoped that the Health Departments in the two cities and counties eventually will be combined into a City-County unit rather than be separate units as they exist today.

Respectfully submitted,  
/s/ Edward B. Mersch  
Edward B. Mersch, Covington  
Councilor, Eighth District

**SPEAKER HOUSTON:** It has been filed and referred to Reference Committee number 1. Ninth District, Dr. Cummings, Flemingsburg.

**DR. CUMMINGS:** The report is filed with the Secretary.

**REPORT OF NINTH COUNCILOR DISTRICT  
TO THE  
1951 SESSION OF HOUSE OF DELEGATES**

The Ninth Councilor District as it now exists, was formed by an alteration in and rearrangement of the counties of the state, in response to the wishes of the members of KSMA as reflected in the passage of an amendment effected by the House of Delegates at the 1951 meeting.

The new Ninth Councilor District was arranged to include the north central Kentucky counties, namely: Bracken, Mason, Fleming, Pendleton, Robertson, Nicholas, Bath, Scott, Harrison and Bourbon. I have personally felt it a great honor, and quite a responsibility, to have been elected as the councilor for this district. The task of assuming the duties of this office was made easier by the kind consideration and cordial friendliness extended by the officers of the KSMA and the present members of the council. In similar respect I have appreciated the thoughtfulness, co-operation, and courtesy shown by the association members throughout our district.

Two district meetings were held during the year and, for a new district, were well attended. The first of these meetings was held February 1951, at the newly erected and splendidly equipped Nicholas County Hospital at Carlisle, Kentucky. After a cordial reception at the home of Dr. B. F. Reynolds, an interesting inspection tour of the hospital was effected, and following the delightful dinner at the hospital, a symposium on "Cortisone and ACTH, Clinical Indications and Use," with presentation of case history and laboratory data was conducted by Drs. George Burger and D. R. Richfield of Covington, Kentucky. The presentation of this subject was most informative.

At Maysville, a fine dinner meeting was held at the New Central Hotel on July 13, 1951. At this meeting we were honored by the presence of our association president, Dr. Sam Overstreet, who spoke on "Medicine in Kentucky, Today and Tomorrow." We were disappointed by the fact that illness prevented the attendance of Dr. Bruce Underwood. Dr. C. E. Reddick very kindly and ably substituted for Dr. Underwood, speaking on "The Responsibilities of the Medical Profession."

In the district there are 84 physicians, 73 of whom are members of KSMA (same as in 1950). Of the 73 active KSMA members only 23 are members of the AMA. Four of the 10 counties in the district have no AMA members. One county, Bath, showed 100% membership in KSMA and AMA.

There are at the present 204 hospital beds in the district, and construction is now under way for an increase of 129 beds. Hospitals are located in 5 of the 10 counties in the district.

The following counties in the district are now participating in the Kentucky Physicians Mutual Insurance program:

Bath	Mason
Bourbon	Nicholas
Bracken	Pendleton
Fleming	Robertson
Harrison	Scott

In closing this report the councilor would like to state that it is his opinion that the people of this district are receiving an increasingly high type of professional service, that there is real evidence of physicians striving to advance themselves educationally and professionally and thus render medical service of increasing value. There exists a close cooperation of the members from the professional viewpoint, despite the inevitable differences in personalities. The attainment of success in "our way of life," it is hoped, shall always be uppermost in our efforts and endeavors, and gradually bring about the closest and firmest union of the physicians in our district and in our state.

Respectfully submitted,

/s/ John R. Cummings

John R. Cummings, Flemingsburg  
Councilor

**SPEAKER HOUSTON:** It has been filed and referred to Reference Committee number 1. Tenth District, Dr. Van Meter.

**DR. VAN METER:** The report has been filed.

#### **REPORT OF TENTH COUNCILOR DISTRICT TO THE 1951 SESSION OF HOUSE OF DELEGATES**

Under the reorganization of districts, the membership of the Tenth District, the second largest in the state, was reduced from 19 counties, with 282 physicians, to two counties (Fayette and Woodford) with 207 physicians. These are divided, ten in Woodford and 197 in Fayette. Many of these listed in Fayette are in hospitals serving internships or residencies or are on the staffs of government hospitals and are not members of the county society.

Fayette holds regular county society meetings each month. These are well planned and well attended. Woodford holds meetings approximately every month.

There is still considerable opposition to the \$25.00 A. M. A. assessment. Of the 152 doctors in the Fayette County Society, 35 have not

paid this assessment; of the 10 in Woodford, 5 have not paid.

The Blue Shield insurance policy is being carried by an increasing number of citizens in this area, but there is need of more vigorous promotion of this policy now that it is available to individuals as well as to groups. It appears to be decidedly the best and cheapest protection even though somewhat limited in its scope, and settlements are made promptly and satisfactorily.

The Councilor of the Tenth District has attended all but one of the regular meetings of the Council and has tried to keep the members of his district posted on the vital business transacted by the Council.

Respectfully submitted,

/s/ J. Farra Van Meter

J. Farra Van Meter, Lexington  
Councilor, Tenth District

**SPEAKER HOUSTON:** Referred to Reference Committee number 1. Eleventh District, Dr. Mahaffey.

**DR. MAHAFFEY:** Mr. Speaker, the report has been filed.

#### **REPORT OF ELEVENTH COUNCILOR DISTRICT TO THE 1951 SESSION OF HOUSE OF DELEGATES**

As of September 18, the Eleventh District is composed of ten counties and has fifty-eight doctors who are members of the State Medical Association. Last year the total number of paid members was sixty-three. Of the present, forty-one have paid their A.M.A. dues. The Eleventh District is a new district composed of Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell and Wolfe counties. At the present time only five counties have organizations, and actually only three counties, Clark, Montgomery and Madison, have regular meetings. Our first annual district dinner meeting was held at the Madison Country Club at Richmond, Kentucky, on July 23, at which time a very good program was presented by Drs. Bruce Underwood, Sam Overstreet and Harry Andrews, all of Louisville. It was very well attended considering the size of our district, about seventy doctors and wives being present.

We notice in the hospital that more and more people have hospitalization insurance, and the number carrying surgical insurance is increasing rapidly. This is not true of the counties outside of hospital centers in our district, however. We feel that a campaign by the Blue Cross and Blue Shield would serve a great need in the district as a whole.

Respectfully submitted,

/s/ Hugh Mahaffey

Hugh Mahaffey, Richmond  
Councilor, Eleventh District



**SPEAKER HOUSTON:** The report has been received and is referred to Reference Committee number 1. Twelfth District, Dr. Carl Norfleet, Somerset.

**DR. NORFLEET:** Mr. Speaker, the report has been filed.

#### **REPORT OF TWELFTH COUNCILOR DISTRICT TO THE 1951 SESSION OF HOUSE OF DELEGATES**

The newly-formed Twelfth Councilor District is composed of eleven counties, two of which, Boyle and Mercer, were added to the former Seventh District when the re-districting program was adopted by the 1950 House of Delegates of the Kentucky State Medical Association.

There are one hundred physicians residing within the Twelfth District, ninety of whom are active members of their component medical societies, thus creating a 90% membership. Sixty-six physicians have paid their A. M. A. dues.

A few county medical societies have held regular monthly meetings. Some counties have so few doctors that regular meetings are not considered practical. However, some of the counties with larger membership have enjoyed some very interesting programs. Members of adjoining counties with smaller membership have been invited and have attended meetings of their neighboring county medical societies.

The Twelfth Councilor District held its annual meeting on June 26 at Lee Ford Dock on Lake Cumberland, near Somerset, Kentucky. The meeting was well attended, and a very interesting program was presented. Many of the doctors came early in the afternoon and enjoyed boat rides and visits to many of the interesting picturesque sites on the beautiful Lake Cumberland.

We are grieved to report the passing of Samuel F. Stephenson, M. D., age 74, Albany, Kentucky, on November 22, 1950. Dr. Stephenson had practiced medicine in Albany, Clinton County, Kentucky, for 52 years.

A ten-week basic course in Electrocardiography, two hours each Friday, was presented by the University of Louisville School of Medicine, Louisville, at Somerset from July 6 to September 7. A goodly number of physicians from the Twelfth District and a few from neighboring districts attended this valuable course.

We are glad to report that the new one-hundred bed Tuberculosis Hospital at London was opened to receive patients last February and was dedicated last June, at which time the hospital was reported to be filled

to capacity. This hospital accommodates some of the counties comprising the Twelfth District.

It was my pleasure to attend a meeting of the Eleventh District at Richmond, Kentucky, and a meeting of the Sixth District at Glasgow, Kentucky. Two very interesting and enjoyable programs were rendered.

During the past year, I have enjoyed meeting and working with the fine groups of professional men of this district. I am sorry I could not visit all the doctors personally. Several visits and special mission trips have been made to various counties of the district. Much of the business as councilor has been conducted by telephone and correspondence.

Good professional relationships seem evident throughout the district.

Respectfully submitted,

/s/ Carl Norfleet

Carl Norfleet, Somerset

Councilor, Twelfth District

**SPEAKER HOUSTON:** Referred to Reference Committee number 1 for study. Thirteenth District, Dr. Sparks, Ashland.

**DR. SPARKS:** The report is filed.

#### **REPORT OF THE THIRTEENTH COUNCILOR DISTRICT TO THE 1951 SESSION OF HOUSE OF DELEGATES**

A gradual increase in Associational interest has been manifested in this newly formed district within the past year. It is heartening to note an increasing number of our doctors are becoming more and more political and civic minded with the idea of helping in this manner to preserve the practice of medicine as a free enterprise profession. It is also heartening to note that a larger number of the younger men are participating in the activities of organized medicine than was the case a few years ago.

This district has endorsed 100% Blue Shield Plans of medical and surgical insurance. We have several rather sparsely populated counties in this district and as a natural result, rather loosely organized medical societies. We have lost two elderly physicians through death in the past year and have gained several very valuable younger practitioners.

Before this year an Eastern Kentucky Medical Association met annually and it embraced this district as well as part of Dr. Hall's new Fourteenth District. Prior to the re-districting of councilor districts this meeting had been arranged and was carried through in a very satisfactory manner.

The statewide meeting of Kentucky Ob-Gyn was held in our district this year. A large

number of practitioners throughout the district availed themselves of the opportunity to attend this meeting. Plans are now being developed for district meetings and other informative programs which should implement the work of our organization.

Respectfully submitted,  
/s/ Clyde C. Sparks  
Clyde C. Sparks, Ashland  
Councilor, Thirteenth District

**SPEAKER HOUSTON:** The report has been received, referred to Reference Committee number 1 for study.

Fourteenth District, Dr. Paul B. Hall of Paintsville. Dr. Hall is not here. Dr. Hall's report has been received and has been now referred to Reference Committee number 1.

#### **REPORT OF FOURTEENTH COUNCILOR DISTRICT TO THE 1951 SESSION OF HOUSE OF DELEGATES**

Medicine in eastern Kentucky has enjoyed a rather healthy year. By that statement we mean there have been no epidemics and no excessive amount of any particular illness.

The profession has been hit hard by the call to colors of many of our men, and this, of course, has worked quite a hardship on the physicians and surgeons left at home. We are very anxious for the day to come when we will have twice as many doctors here in the foothills of the Cumberlands as we now have. The people need them, and practically all the doctors here would like to have that many more doctors. All could make a good living, the people would get better service and to have lots of good doctors would put a "better taste" in the minds of the people and would certainly be a big step toward putting an end to socialized medicine gossip for all time to come.

We shared our councilor meeting with Dr. Clyde Sparks at Ashland this year because of his gracious invitation—we hope to have his crowd with us next year.

There has been no increased activity in county society meetings, and I doubt if there will be until this war scare is over and most of the boys come home.

The doctors in our territory are very proud of our magazine and the large amount of information sent out to them from our State Headquarters. We feel like we have a real Headquarters Force.

Respectfully submitted,  
/s/ Paul B. Hall  
Paul B. Hall, Paintsville  
Councilor, Fourteenth District

**SPEAKER HOUSTON:** Fifteenth District, Dr. Charles D. Cawood, Middlesboro. Dr. Cawood isn't here. His report is received and has now been referred to Reference Committee number 1.

#### **REPORT OF FIFTEENTH COUNCILOR DISTRICT TO THE 1951 SESSION OF HOUSE OF DELEGATES**

The Fifteenth Councilor District is composed of seven counties, namely Bell, Clay, Harlan, Knox, Laurel, Leslie and Whitley. These counties are in the southeastern section of the state, and two of these counties, Clay and Leslie, have less than five physicians. Clay County has three physicians and Leslie County has only two. Bell County has 32; Harlan, 49; Knox, 9; Laurel, 11; and Whitley, 20. It is realized that some of these physicians are inactive and retired, and some of them have only a limited license to practice under the Kentucky law.

During the current year, your councilor has visited several of the counties in his district, and on September 13 there will be a district meeting held at Clear Creek Springs, which is near Pineville. Your councilor has assisted in an advisory capacity the Kentucky Procurement Committee with problems in the fifteenth District. In carrying out the responsibilities as an advisor, the councilor recommended to the individual societies that they appoint three men from their society to assist in procurement medical problems. This has been done in each county with the exceptions of Leslie and Clay.

Since it is impossible for me as a councilor to devote sufficient time to the problems of this district, I have extended my resignation to the Secretary of the Kentucky State Medical Association. I feel that with so many problems arising in this district the physician who succeeds me as councilor should have sufficient time to make frequent visits to the various societies, arrange more district meetings and have more time to devote to the Kentucky Procurement Committee.

I appreciate very much the assistance that has been given to me by the Council of the Kentucky State Medical Association, Dr. Bruce Underwood, our capable Secretary, and our Executive Assistant, Mr. Joe Sanford.

Respectfully submitted,  
/s/ Chas. D. Cawood  
Charles D. Cawood, Middlesboro  
Councilor, Fifteenth District

**SPEAKER HOUSTON:** Now we will have the report of the delegate to the American Medical Association, Dr. J. Duffy Hancock of Louisville.



DR. HANCOCK: Mr. Chairman, members, there is a copy of this report in your folder, but because of the question of an appropriation being involved we have been asked to read this report to you.

**REPORT OF DELEGATES TO THE  
AMERICAN MEDICAL ASSOCIATION TO  
1951 SESSION OF HOUSE OF DELEGATES**

**Report of A. M. A. House of Delegates Meeting  
Held June, 1951, in Atlantic City**

Your three delegates, Drs. J. B. Lukins, Bruce Underwood and I, were present at all sessions of the House of Delegates on Monday, Wednesday and Thursday and attended committee meetings on Tuesday. The total number of Kentucky physicians registering at the A.M.A. meeting was 90.

For the first time there were two special delegates—representing the newly-formed Student American Medical Association.

In his address as retiring president, Dr. E. L. Henderson discussed many activities and plans of the A. M. A. Several of them should be emphasized.

An arrangement is being developed whereby hospital standardization which seemed in danger of being taken over by the American Hospital Association will be under the joint auspices of that organization, The American College of Surgeons, the American College of Physicians, and the American Medical Association. The majority control will be in hands of physicians with the A. M. A. having the largest number of representatives. These A. M. A. representatives will be divided among various groups with the general practitioners being recognized.

The American Medical Education Foundation established to aid medical schools in meeting their operating expenses has received generous contributions. As you know, the government has before it several bills to give funds to medical schools, and it has been felt that these funds should be limited to funds that are expended one time, such as for equipment or buildings, and that they should not be recurring donations which might give the government the privilege of saying how these funds should be used in the teaching and management of schools. Among these were \$2000 from The American College of Radiology, \$10,000 from The Woman's Auxiliary, \$100,000 from The California Medical Association and \$10,000 from South Carolina. The Medical Society of the State of New York has set \$250,000 as its objective. A chairman has been appointed for Kentucky and your personal contributions will be solicited. Incidentally, any

contribution can be designated to go to some specific medical school. Contributions from industry are being secured by the National Fund for Medical Education, and the two organizations have recently merged. Your delegates recommend that The Council of the State Medical Association be directed to make an appropriate contribution to the American Medical Education Foundation for this fund.

Improvement in public relations has been encouraged by promoting voluntary health insurance, by effective use of grievance committees, by aiding the establishment of 24-hour emergency medical service in the various communities, and by emphasizing the training of good general practitioners.

When it was called to the attention of the House of Delegates that the contract of Whitaker and Baxter, who had directed the National Education Campaign, had terminated, it was voted to re-employ them on a part-time basis to carry on a continuing fight against efforts to establish socialized medicine.

Your delegates were asked to submit only one resolution. It was initiated by the Kentucky Chapter of the Academy of General Practice and requested that efforts be made to have the Blue Cross compensate the physician for the use of his physical facilities just as it does hospitals for their emergency rooms. The resolution was lost in the committee because some of the members were over zealous in their opposition to the Blue Cross having anything to do with physicians' bills. An attempt to over-rule the committee report also failed. This resolution seems to have much merit particularly in a state like Kentucky, where often the physician's office offers the only hospital facility for the community. Another effort will be made to have this resolution passed at the December 1951 meeting at Los Angeles.

We had conferences with the chairman of this committee after the final vote, and I think that he will be favorably disposed to the re-introduction of this resolution. There was simply a fear that the Blue Cross would have something to do about the payments of doctors' bills, and we couldn't get it over to them that this was the resolution to pay not for the doctor's services but for the use of his facilities, and I think with that distinction made more clear that we should have better luck at the next session.

Announcement was made of the continuing fight to secure legislation which would permit professional self-employed persons, which would include practicing physicians, to deduct from their gross income, payment for retirement pensions such as are now available to

executives and other employees. Such legislation is in the present finance bill being considered in the Senate. There is an amendment called the Ives Amendment which was introduced by Senator Ives of New York. This amendment, which you are all urged to write to your senators about and ask their support for, would allow a deduction from ten to fifteen per cent of the gross income before taxes were figured out and deducted to pay into a retirement fund. It is only fair that this should be done. The white collar executives in large corporations have it done for them. The employees have it done, and the self-employed such as physicians should have that same privilege. If any of you can take the time to do it, I would suggest that you write Senator Underwood and Senator Clements urging their support of the Ives Amendment.

The necessity for whole-hearted support of the blood bank was emphasized and endorsed.

Membership dues for 1952 were set at \$25.00 which is to include subscription to the Journal of the American Medical Association.

Your delegates were well impressed by the efficient and democratic procedure of the House of Delegates. The newly-elected officers seemed to be outstanding selections, and the administrative personnel appeared to be enthusiastic and competent. We feel that as members of the A. M. A. our interests and also those of the public at large will be properly advanced. It is a matter of considerable regret that our paid membership as of September 10, 1951 was only 1,320. One of the bad features of this low number of members is that we will probably have a reduction in the number of delegates allotted to our State Medical Society. All of you are urged to encourage those who have been careless or indifferent about their dues to pay them and reinstate themselves in good standing. All of us will benefit by a better numerical showing than we now have.

Respectfully submitted,

DELEGATES FROM KENTUCKY  
TO THE AMERICAN MEDICAL  
ASSOCIATION

/s/ J. B. Lukins

J. B. Lukins, Louisville

/s/ Bruce Underwood

Bruce Underwood, Louisville

/s/ J. Duffy Hancock

J. Duffy Hancock, Louisville

Mr. Speaker, there is another portion of this which I think should be presented by Dr. Lukins or Dr. Underwood. It deals with the interim meeting last year where I was not in attendance.

DR. SCOTT: Mr. Speaker, is it in order to ask Dr. Hancock a question in clarification of of this report?

SPEAKER HOUSTON: I think just a short question will be all right.

DR. SCOTT: The question of dues, is \$25 the complete? What about the fellowship dues, does that make a man a fellow of the Association, or would you tell us the facts briefly as to that?

DR. HANCOCK: Mr. Speaker, there was considerable discussion in the House of Delegates regarding fellowships. At the present time the fellowship dues have been an additional \$5 above the regular dues, and this was left in effect for the coming year that fellowship dues will be an additional \$5; however, in the House of Delegates there was a very sizable group that were opposed to a distinction between members and fellows, and whether the solution will be to name all members fellows or to do away with fellowships is something that is to be considered further at the December meeting.

SPEAKER HOUSTON: We will now hear from either one of the other delegates who can report on the interim session.

DR. BAILEY: Mr. Speaker, this session of the A. M. A. House of Delegates followed almost immediately the November elections whereby the voters in the majority had expressed themselves overwhelmingly against the candidates who supported plans for the socialization of medicine. It was the sense of medical opinion that important gains had been made in our fight to preserve our freedom of medical practice.

Our delegates were unusually busy and took pride in the fact that a Kentuckian, Dr. Elmer L. Henderson, was President of the American Medical Association. Dr. Henderson addressed the House of Delegates discussing five important subjects: financial support of medical education, the position of the American Medical Association with respect to hospital standardization, public health units, the results of the A. M. A. nation-wide advertising program and the significance of the November elections. The importance of Dr. Henderson as president, together with the activities of your three delegates placed Kentucky in an enviable position.

The Board of Trustees announced to the House of Delegates the appropriation of a half million dollars out of its National Education Campaign Fund, which was raised to defend medical freedom, for the aid and support of medical schools which are in need of additional financing. This fund is to be given to medical schools for their unrestricted use. This



action was widely acclaimed not only in the House of Delegates but throughout the entire United States as a positive approach toward the solution of one of the more serious immediate problems of medicine.

The Scientific Session was one of the best of any Interim Session held so far. Both Scientific and political developments left the impression that the efforts of those who love their medical profession had not been made in vain.

Respectfully submitted,

DELEGATES FROM KENTUCKY  
TO THE AMERICAN MEDICAL  
ASSOCIATION

/s/ J. B. Lukins

J. B. Lukins, Louisville

/s/ Bruce Underwood

Bruce Underwood, Louisville

/s/ Clark Bailey

Clark Bailey, Harlan

**SPEAKER HOUSTON:** We will refer both of the reports from our delegates to the A. M. A. to Reference Committee number 1.

If there are any questions in that report that you wish to study, wish to discuss, please present yourself at that meeting.

I now have a second vote on the J. Watts Stovall Award. Dr. Hiestand 19, Dr. Kincheloe 32, Dr. Coblin 38—I beg your pardon, Dr. Hiestand 14, Dr. Coblin 41, and Dr. Kincheloe 45. I have a total vote net of 100. We do not have a majority and will have to have one more ballot to decide that award. We will vote for the last time on the J. Watts Stovall Award between Dr. Coblin of Frankfort and Dr. John Kincheloe of Hardinsburg. I will ask that the first tellers please spread the ballots one more time.

Are all the ballots in? I declare the balloting closed. While the tellers are giving us the report of this ballot, we will have the reports from the standing committees of the Association. The first committee, the Committee on Scientific Assembly, Dr. Sam Overstreet, Louisville.

**DR. OVERSTREET:** My report begins to unravel itself in the morning at nine o'clock. I hope that you are here to hear it, and it will wind up Thursday afternoon at four.

#### REPORT OF THE COMMITTEE ON SCIENTIFIC ASSEMBLY TO THE 1951 SESSION OF THE HOUSE OF DELEGATES

The Council approved the request of this committee to invite as participants on our program Kentucky physicians who had distinguished themselves outside the state. The program has been so arranged and we believe

satisfies our most optimistic expectation. The program is submitted to the delegates and members of the Association for their approval.

#### TUESDAY, OCTOBER 2, 1951

##### First Scientific Session

R. B. Chrisman, Jr., M. D., Miami, Florida—"Doctors are Citizens Too."

W. Gayle Crutchfield, M. D., Charlottesville, Virginia—"Unilateral Upper Extremity Pain."

Drew Luten, M. D., St. Louis, Missouri—"Some Physiological Considerations in the Treatment of Patients with Congestive Heart Failure."

Carl Fortune, M. D., Lexington, Kentucky—Oration in Medicine—"The Medical Management of Anuria and Oliguria."

##### Second Scientific Session

Otho C. Hudson, M. D., Hempstead, Long Island, New York—"The Use of Excision of Head in the Treatment of Fracture of the Neck of the Femur."

Leonard Heaton, M. D., Major General—U. S. Army, San Francisco, California—"Recent Observations on Frostbite."

Fred P. Helm, M. D., Austin, Texas—"Infant Mortality as Related to the Three Leading Causes of Death."

William H. Wilson, M. D., New Haven, Connecticut—"Coeliac Disease—From the Department of Pediatrics of the Yale University School of Medicine and University Service, Grace—New Haven Community Hospital."

##### Third Scientific Session

Hugh Jeter, M. D., Oklahoma City, Oklahoma—"Why Anemia?"

Elbert DeCoursey, Brig General (MC) U. S. Army, Washington, D. C.,—"Human Injury from Atomic Explosion."

Harry Beckman, M. D., Milwaukee, Wisconsin—"Not in the Thing Itself."

Charles Maguire, M. D., Louisville, Kentucky—Oration in Surgery—"Pediatric Surgery Comes of Age."

##### Fourth Scientific Session

Henry H. Turner, M. D., Oklahoma City, Oklahoma—"Hypogonadism and Infertility in the Male."

Henry W. Cave, M. D., New York, New York—"Acute Surgical Abdomen."

Daniel C. Elkin, M. D., Emory University, Georgia—"The Diagnosis and Treatment of Aneurysms and Arteriovenous Fistulas."

Robert P. Kelly, M. D., Emory University, Georgia—"Injuries of the Ankle."

#### Fifth Scientific Session

Dwight M. Kuhns, M. D., Colonel (MC) U. S. Army, Washington, D. C.—"Observation of Tropical Diseases During and Following World War II"

Fred W. Rankin, M. D., Lexington, Kentucky—"Encouragements in Cancer Surgery."

Arthur W. Allen, M. D., Boston, Massachusetts—"Ulcer and Cancer of the Stomach."

Russell L. Cecil, M. D., New York, New York—"Cortisone and ACTH in the Treatment of Chronic Arthritis."

#### Sixth Scientific Session

Earl E. Gambill, M. D., Mayo Clinic, Rochester, Minn.—"Relapsing Pancreatitis."

Julian Johnson, M. D., Philadelphia, Pennsylvania—"The Present Status of Cardiac Surgery."

Robert P. Ball, M. D., Baton Rouge, Louisiana—"Angiography."

Arthur L. Juers, M. D., Miami, Florida—"Deafness—Its Present Day Management."

Respectfully submitted,

COMMITTEE ON SCIENTIFIC  
ASSEMBLY

/s/ Sam A. Overstreet

Sam A. Overstreet, Louisville,  
Chairman

W. Clark Bailey, Harlan

Morris Flexner, Louisville

J. Duffy Hancock, Louisville

Bruce Underwood, Louisville, Sec-  
retary

**SPEAKER HOUSTON:** His report has been referred to Reference Committee number 1. The report of the Committee on Arrangements, Dr. Bailey.

**DR. BAILEY:** The report has been filed.

#### REPORT OF THE COMMITTEE ON ARRANGEMENTS TO THE 1951 SESSION OF HOUSE OF DELEGATES

The Centennial Meeting of our Association is being held for the second time here at the Columbia Auditorium. Because of the increased amount of space, it is possible to have a greater variety of instruction for our members.

All of the scientific sessions of the Association, all meetings of the House of Delegates and Reference Committee meetings, the lar-

gest display of scientific and technical exhibits in the history of the Association, scientific movies and numerous other meetings are being held here.

The General Public meeting is being held in this room this evening, 8:00 P. M., Tuesday, October 2nd. A most interesting program has been arranged for this meeting, depicting the life of Dr. Ephraim McDowell, the father of modern abdominal surgery, through the presentation of "Living Portraits." The Woman's Auxiliary is cooperating in the management of this part of the program. Our guest speaker for the evening is to be Dr. Lewis J. Moorman, of Oklahoma City, Oklahoma, whose subject will be, "Kentucky—The Progenitor of Pioneer Doctors."

Wednesday, October 3rd, at 12:00 noon, is the time for the President's luncheon, at which time our distinguished guests will be honored. At this meeting Dr. John W. Cline, President of the American Medical Association, will address our members. This luncheon meeting will be held on the Roof Garden of the Brown Hotel and is arranged in the hope that all members present at the meeting will attend and become better acquainted with the problems and policy of our profession as determined from the national level.

The Woman's Auxiliary is holding its annual session at the Brown Hotel at the same time as our meeting. Arrangements have been made by their own organization for their meeting.

Arrangements have been made for the Annual Banquet Thursday evening, in the Crystal Ball Room at the Brown Hotel, October 4th, at 7:00 P. M. The President of our Association, Dr. Sam A. Overstreet, will deliver his address at this meeting. The "Charge to New Members" will be given by the President-Elect. The President of the Association will be installed. Recognition of class reunions will be made.

Respectfully submitted,

COMMITTEE ON ARRANGEMENTS

/s/ Clark Bailey

W. Clark Bailey, Harlan, Chairman

Charles M. Edelen, Louisville

Charles F. Long, Elizabethtown

B. J. Baute, Lebanon

William H. Pennington, Lexington

**SPEAKER HOUSTON:** The report of the Committee on Arrangements is referred to Reference Committee number 1. The Committee on Public Relations, Dr. Overstreet.

**DR. OVERSTREET:** The report of the Committee on Public Relations is on file, and I think needs no further comment.



## REPORT OF COMMITTEE ON PUBLIC RELATIONS TO THE 1951 SESSION OF HOUSE OF DELEGATES

The activities of the Public Relations Committee are recorded in the minutes of the Council Meeting, relating to such matters as have been assigned for consideration. The committee was requested by the Council to prepare a statement of policy as a general guide for the Association. The statement of policy was prepared and submitted to the meeting of the Council on August 30, 1951, for approval. The statement of policy is attached to this report.

It has been provided that the chairman of the Committee on Public Relations be President of the Kentucky State Medical Association. It is believed by your chairman that this provision should be corrected. The demands now being made upon the time of the President of the Association are such that he should not be required to direct the activities of one of his principal committees.

### Twelve Objectives of the Kentucky State Medical Association

#### ETHICS

1. To constantly improve the high standard of ethics of our profession and inspire by example and precept among medical students and young practitioners a sanctity of the trusts committed to us.

#### CITIZENSHIP

2. To encourage the members of our profession to participate in local activities of civic improvement and building of good American citizenship.

#### LEADERSHIP

3. To assume an alert leadership in all matters pertaining to health to the end that we may provide for all Kentuckians the best medical care which the State's resources will afford.

#### COOPERATION

4. To secure the cooperation of all professions and agencies in a constructive and progressive program of health throughout the state.

#### PREPAID CARE

5. To promote prepaid hospital and sickness insurance to individuals as well as groups through our own and reputable private agencies.

#### THE PUBLIC

6. To inform the public of the problems of medical service and how they may secure the best medical care, and to solicit their confidence and cooperation in efforts devoted to their best interest.

#### INDIGENTS

7. To provide more equitable and adequate medical care for indigent citizens in every community.

#### PUBLIC HEALTH

8. To actively cooperate with the State Department of Health and with local health departments in initiating and carrying out a sound public health program designed to control preventable disease and to safeguard the health of the people.

#### INSTITUTIONS

9. To constantly promote the improvement of curative medical care in our State Tuberculosis and Mental Hospitals and to coordinate and support programs that combat heart disease, cancer, diabetes, poliomyelitis, and other similar devastating diseases.

#### HOSPITALS

10. To expand and improve present hospital facilities to the end that all citizens may have available within their reach the benefits of the best scientific diagnosis and treatment of disease.

#### EDUCATION

11. To educate an adequate number of physicians, nurses, and technicians and seek their more equitable distribution to all communities; to foster medical research and extend to all the benefits of postgraduate study.

#### LEGISLATION

12. To maintain close liaison with the Federal, State and County government to the end that the best health interests of our citizens will be served.

Respectfully submitted,

COMMITTEE ON PUBLIC RELATIONS

/s/ Sam A. Overstreet

Sam A. Overstreet, Louisville, Chairman

David M. Cox, Louisville

R. Haynes Barr, Owensboro

O. O. Miller, Louisville

Bruce Underwood, Louisville

SPEAKER HOUSTON: We have received his report and it will be referred to Reference Committee number 1.

We have the report of the Education Campaign Sub-committee, Dr. R. Haynes Barr.

DR. BARR: Mr. Speaker, that report has been filed and is contained in the envelope.

## REPORT OF EDUCATION CAMPAIGN SUBCOMMITTEE TO THE 1951 SESSION OF HOUSE OF DELEGATES

For the first few months following the annual meeting of the Kentucky State Medical Association due to the geared-up tempo of the program for the general elections of Novem-

ber 1950, the personnel, objectives and methods of this Committee remained unchanged. The views of all candidates for Congress and the Senate were obtained and passed on to the physicians of Kentucky through the PR letter. While no actual political work was done by this Committee or in the name of the State Medical Association, individual physicians in various parts of the State did outstanding work in behalf of those candidates who had shown themselves to be friends of free enterprise and American medicine. On a few occasions addresses were made in neighboring states at the request of our colleagues in those states. It is hardly necessary now to remind you of the signal success at the polls of the over-whelming majority of candidates who came out flat-footedly against socialized medicine and socialism of all kinds.

Following the elections of November 1950 there appeared only a remote possibility that any legislation socializing medicine would be passed by the present Congress, which caused an inevitable lapse in interest and activity on the part of individual physicians. The members of this committee continued to make addresses and, ably assisted by the Woman's Auxiliary, continued to obtain resolutions against compulsory health insurance from all types of lay groups, hand out literature, though requested in somewhat smaller quantities, which continues to be effectively used by many physicians over the state.

In the spring of 1951, acting under the directives of the president and the council, the entire education committee was revamped and reorganized to better enable it to give all-out assistance to an ambitious program of legislation within the state. Specifically, this new assignment was to carry on an educational program in support of such legislation in the public interest as was recommended by the Legislative Committee and accepted by the Council and House of Delegates. To insure the success of such a mission, the various Councilors were asked to nominate from their respective areas those physicians most experienced in "practical politics" and if possible the personal physicians of key figures in state government. From the list submitted, the President appointed a rather large new education committee with a comprehensive geographical distribution. This new Committee has had no meetings as yet but it appears likely that it will have much to do between now and the date of adjournment of the 1952 General Assembly.

In the meantime an ever alert eye has continued to be turned toward Washington where many so-called fringe bills and proposed laws containing fragments of socialized medicine are being bounced around in committees. This Committee has held itself in readiness to function on a national level when, and if necessary. It has continued the policy of the monthly Public Relations letters as a means of keeping the physicians in Kentucky informed in this field.

Respectfully submitted,  
EDUCATION CAMPAIGN SUBCOMMITTEE

/s/ R. Haynes Barr  
R. Haynes Barr, Owensboro, Chairman  
J. F. Harrell, Bardwell  
R. Ward Bushart, Fulton  
James W. Fuller, Mayfield  
George C. McClain, Benton  
R. W. Robertson, Paducah  
Charles B. Wathen, Owensboro  
F. M. Griffin, Hawesville  
Walter L. O'Nan, Henderson  
A. B. Colley, Calhoun  
Fred C. Reynolds, Jr., Hartford  
Dudley B. Smith, Morganfield  
William W. Wainer, Providence

Joe M. Bush, Mt. Sterling  
Don E. Wilder, Booneville  
B. K. Amos, Princeton  
J. G. Gaither, Hopkinsville  
I. W. Johnson, Stanton  
John L. Cox, Campton  
Charles W. Caldwell, Jr., Danville  
Garnett J. Sweeney, Liberty  
Ernest A. Barnes, Albany  
Paul M. Sides, Lancaster  
Thomas J. Wright, Stanford  
Grover C. Meece, Whitley City  
C. S. Van Arsdall, Harrodsburg  
Richard H. Weddle, Somerset  
George H. Griffith, Mt. Vernon  
M. M. Lawrence, Jamestown  
Frank L. Duncan, Monticello  
Mathew D. Garred, Ashland  
Grady C. Stewart, Olive Hill  
John F. Greene, Sandy Hook  
Charles B. Johnson, Russell  
Herbert M. Bertram, Jr., Vanceburg  
G. Philip Carter, Louisa  
John E. Haynes, Dawson Springs  
M. H. Moseley, Eddyville  
John P. Walton, Central City  
Ralph D. Lynn, Elkton  
John Futrell, Cadiz  
Charles L. Sherman, Millwood



James W. Miller, Greensburg  
 William H. Barnard, Elizabethtown  
 James W. York, Canmer  
 John D. Handley, Hodgenville  
 W. Burr Atkinson, Lebanon  
 Alfred Glattauer, Brandenburg  
 W. Keith Crume, Bardstown  
 Martin H. Skaggs, Taylorsville  
 D. E. Snider, Springfield  
 J. Andrew Bowen, Louisville  
 Nathaniel A. Mercer, Columbia  
 Earl P. Oliver, Scottsville  
 William H. Bryant, Glasgow  
 Alec Spencer, West Liberty  
 I. M. Garred, Morehead  
 Myrvin E. Hoge, Jackson  
 George Archer, Prestonsburg  
 D. H. Dorton, Jr., Paintsville  
 M. F. Kelly, Hindman  
 Ernest G. Skaggs, Fleming  
 Lloyd M. Hall, Salyersville  
 William N. Keith, Inez  
 Lawrence H. Wagers, Blue Diamond  
 Francis H. Hodges, Pikeville  
 Charles B. Stacy, Pineville  
 William E. Becknell, Manchester  
 Philip J. Begley, Harlan  
 Theodore R. Davies, Barbourville  
 Boyce E. Jones, London  
 Keith P. Smith, Corbin  
 J. Bates Henderson, Berea  
 Albert B. Hoskins, Beattyville  
 Arch B. Clark, McKee  
 D. G. Miller, Jr., Morgantown  
 Marcus B. Wilkes, Jr., Brownsville  
 C. A. Wood, Auburn  
 Elgin S. Dunham, Edmonton  
 Tim Lee Carter, Tompkinsville  
 Lillard F. Beasley, Franklin  
 William R. McCormack, Bowling Green  
 R. N. Lawson, Lawrenceburg  
 Edgar S. Weaver, Carrollton  
 Clarence T. Coleman, Frankfort  
 Harry K. Dillard, Warsaw  
 C. Wyatt Norvell, New Castle  
 John T. Walsh, LaGrange  
 John F. Berry, Jr., Owenton  
 Benjamin F. Shields, Shelbyville  
 O. James Hurt, Bedford  
 Arthur F. Schultz, Newport  
 Norman Adair, Covington  
 B. Ralph Wilson, Sharpsburg  
 William W. Dye, Paris  
 Samuel G. Marcum, Irvine  
 Vernon O. Kash, Winchester  
 Benjamin F. Roach, Midway  
 John S. Sprague, Lexington  
 Frederick W. Wilt, Georgetown  
 Perry Overby, Mt. Olivet  
 James M. Stevenson, Brooksville  
 Ben F. Allen, Flemingsburg

H. Todd Smiser, Cynthiana  
 Harold N. Parker, Maysville  
 B. F. Reynolds, Carlisle  
 William M. Townsend, Falmouth

**SPEAKER HOUSTON:** You have his report and it is referred to Reference Committee number 1.

The report of the Medical Economics Committee, Dr. Simpson.

**DR. SIMPSON:** Mr. Speaker, the report has been filed.

#### **REPORT OF COMMITTEE ON MEDICAL ECONOMICS TO THE 1951 SESSION OF HOUSE OF DELEGATES**

The most important single topic referred by the Council to this committee for discussion concerns the desirability of establishing a Medical Advisory Committee, on a state and county level, to cooperate with the Department of Economic Security, the County Fiscal Courts, the Kentucky Hospital Association, the Kentucky Pharmaceutical Association, and many other interested agencies—the function of which is to make a complete survey of the needs of a medical program for the indigent who are clients of the Department of Economic Security—and serving of course on a voluntary basis, without authority, except to influence legislators to the extent that state funds be made available to supplement federal funds now accessible through Public Law 734 to offer adequate medical care to these clients.

There have been three formal meetings concerning this matter during the past year, the most recent of which was August 22. Some progress is being made, but nothing definite can be accomplished until certain enabling legislation is passed by the General Assembly. Each member of the Kentucky State Medical Association will have received prior to the October meeting, from State Headquarters and provided by the Medical Economics Committee, a brief booklet describing the welfare programs as now administered in certain states.

This committee recommends to the Council and House of Delegates that it be permitted to pursue this problem with assistance from the Judicial Committee of the Kentucky State Medical Association, and, if at all possible, work out something of this nature.

The Medical Economics Committee has joined the University of Louisville Medical School, the Kentucky Chapter of the American Heart Association, and the Kentucky State Department of Health in conducting a survey of three counties selected at random throughout the state to determine just what funds and facilities are available for a chronically ill indigent patient.

Third, one formal meeting was devoted entirely to a thorough discussion of the question of whether or not it is desirable to establish a medical school as a department of the University of Kentucky in Lexington, and also a hospital to be used by the medical school—it being planned to secure indigent patients for teaching purposes by transporting them by ambulance from communities throughout the state. We conclude after much consideration and discussion and do recommend to the House of Delegates and the Council that the University of Louisville Medical School Plant be assisted in expansion by state funds, and that no school be constructed in Lexington at this time. It is felt that if a sum of money equal to that required to operate a medical school in Lexington were made available by the State of Kentucky to the University of Louisville annually, that the problem would be solved and the taxpayers spared the cost of establishing a plant in Lexington. There is a strong feeling among the members of this committee that indigent patients be hospitalized in their own communities where possible, and that we would be very reluctant to recommend any program which requires the transportation, for any great distance, of any group of patients, indigent or otherwise.

Fourth, the McCracken County Medical Society presented the Council with a problem concerning Blue Cross Medical Insurance and applying to employees of the U. S. Steel Corporation who reside in and near Paducah. The gist of the controversy arose over the Blue Cross refusing to pay private anesthetists and private electrocardiologists, whereas they would compensate the hospital for such services. Blue Cross had secured from the State Health Department a charter for a certain number of months with such provisions and the arrangement had been approved by the Council at an earlier date. After an extensive investigation and much discussion, the Medical Economics Committee recommended to the Council that the State Health Department be advised of the objection to this matter by the McCracken County Medical Society and that the Council recommend to the State Health Department that it approve a new contract with U. S. Steel and Blue Cross, with a deletion of the provision allowing Blue Cross to pay hospital personnel for these various services where the payments are withheld from a private physician.

Fifth, there has been some controversy as to the method of selecting physicians to conduct medical examinations of the parents of dependent children who are clients of the State Department of Economic Security, it being

argued that any physician, preferably the client's family physician, conduct the examination. The matter was discussed with Mr. Paul, who represents the Department of Economic Security in this matter, and from him it was learned that in many instances a client was able to apply an uncomfortable amount of pressure to his family physician, and that through such pressure and sympathy they felt that their relief load would possibly be heavier than if it were handled by some physician who was less familiar with the economic status, etc., of the applicant. In view of this feeling, the eleven districts of the state each have two examiners appointed by the Department of Economic Security to conduct examinations. Our committee, after discussing this problem, recommends to the Council that no change be made in this arrangement at present. It is our feeling that their explanation of the matter has some merit.

The sixth problem which occupied time concerns the fact that the fiscal court in a good many counties in Kentucky fails to make adequate provision, as provided for by law, for medical care to the indigents, including hospitalization, etc. It is the opinion of the Medical Economics Committee that in many instances even though the fiscal court feels kindly towards this matter there are just not sufficient funds in the county treasury to carry out a proper program. It is our hope that through the Medical Advisory Council mentioned in the first paragraph of this report, that an excellent program can be worked out to solve this problem. We therefore recommend at this time that no action be taken by the Judicial Committee on this matter per se.

Respectfully submitted,

COMMITTEE ON MEDICAL ECONOMICS

/s/ G. L. Simpson, Greenville,  
Chairman

Carl Norfleet, Somerset

C. C. Howard, Glasgow

John E. Haynes, Dawson Springs

B. B. Eaughman, Frankfort

**SPEAKER HOUSTON:** We have received the report and it has been filed with Reference Committee number 2 for study.

The Medico-Legal Committee, Dr. J. B. Lukins.

**DR. LUKINS:** The report is prepared and is filed.

#### **REPORT OF MEDICO-LEGAL COMMITTEE TO THE 1951 SESSION OF HOUSE OF DELEGATES**

In a recent issue of a very popular medical publication there appears an article entitled "Eight Ways to Invite a Malpractice Suit." All



the points except two mentioned in this article have been stressed in our annual report through the years, particularly the one where we have asked you to not neglect an X-ray examination where there is any probability of a bone injury. The other, about demanding payment of the bill where there is any question of neglected treatment on the part of the patient or family.

These two points particularly have been so well received by the profession in Kentucky and made of practical use that it is now a rarity to have a malpractice suit based on either one of these contentions.

The two in this article that up to now have not been stressed are: (1) Performing an unauthorized second operation. Recently, a very satisfactory pelvic operation was done on a patient and then at the suggestion of a bystander a mole was removed from the front of the neck. This had not been mentioned by or to the patient. An ugly scar resulted and this resulted in a malpractice suit. (2) The second point I wish to emphasize is that of the attending physician leaving town without providing a substitute. In these days most doctors are too busy and by all means should have a vacation. To leave patients without a definite understanding of who is to take care of those already ill is a mistake and could result in serious consequences.

Episiotomy is a minor operation that in recent years has become very popular. I am told that some obstetricians practice it 100% in primipara. We now have two suits for bad results from this operation and just in the last few days another threatened. I would suggest that some explanation be made to the patient and family why this operation is done, and of course all precautions taken to prevent infection.

There are now pending in court in Kentucky eight cases. These claims range all the way from an injured nerve by injection of Theelin to a declaration of insanity in which six different doctors were in complete agreement. Most of these cases are without merit, but one or two are giving us work and worry and considerable expense. To show the vagaries of human nature, I might mention there is one case claiming that a sterilization operation was done without consent, and the next case for not doing a sterilization when the surgeon said it was not indicated—the only reason being the patient wanted it done.

We have won three cases in court and have lost one. There have been three cases compromised for small amounts. There are several threatened cases, but only two that appear to be of serious nature. The latest report of the

Medico-Legal Committee of the A.M.A. shows that malpractice suits are on the increase. So far this is not the case in Kentucky. We will continue to emphasize the fact that the average case can be prevented. The total expense to the Association for the year has been \$500.-00. This is the least we have spent in 27 years.

Consultations, friendliness and cooperation of neighboring physicians continue to be our chief bulwark against worry and damaged reputation. Prevention is the best defense against malpractice. Criticism of our competitors and statement of opinion about a case in which we do not know all the facts are often the small flames that generate a malpractice suit.

Our doctors and our attorney, Mr. Roy Curtis, have responded 100% in investigation and preparation of defense in all of our cases.

Respectfully submitted,

MEDICO-LEGAL COMMITTEE

/s/ J. B. Lukins

J. B. Lukins, Louisville, Chairman

Woodford B. Troutman, Louisville

Bruce Underwood, Louisville

W. Clark Bailey, Harlan

Lanier Lukins, Louisville

**SPEAKER HOUSTON:** You have Dr. Lukin's report. I will refer it to Reference Committee number 2 for study.

The Committee on Medical Education, Dr. Scott. Dr. Scott's report is in and is being referred to Reference Committee number 2 for study.

#### **REPORT OF COMMITTEE ON MEDICAL EDUCATION TO THE 1951 SESSION OF HOUSE OF DELEGATES**

Your Committee on Medical Education has concerned itself with three major aspects of the problem: (1) pre-medical education, (2) the medical school, and (3) post-graduate training within the state.

There has been a tendency for some twenty years for colleges to offer subjects of a specialized nature which should be restricted to the curriculum of the medical school. These must be repeated and are better taught in the medical school. Your committee believes that there is a growing conviction among the deans of medical schools that such courses in the pre-medical curriculum serve no useful purpose. They detract from the time college students should devote to acquiring general education in cultural subjects and in the basic sciences. Colleges had best concern themselves with producing well educated candidates for admission, grounded in the basic sciences, cultural subjects and the languages, leaving histology, anatomy, endocrinology, allergy and the like to the medical schools.

With regard to medical education within the state, there are two schools of thought. Some feel that the University of Kentucky should have a medical school in Lexington, and that state funds should be allocated only to schools which are under state control. Though it would seem desirable to locate most academic institutions in the quiet atmosphere of a smaller community, away from the distractions and diversions of the city, the site of a medical school involves other problems. Such an institution requires clinical material of a sort found only in the larger centers. The cost of buildings and maintenances of an adequate medical faculty, part of which would serve on a full-time basis, would place enormous burdens of taxation on the citizens of the state without commensurate returns to them. The course of wisdom and economy would be to support, expand and improve our already existing facilities at the University of Louisville. (This is the opinion of the chairman without committing the two members of the faculty of the Medical School, Drs. Kinsman and Clay, who are on this committee.)

In postgraduate training the State Medical Association should play a prominent role. It is our belief that every physician should be encouraged and enabled to keep abreast of developments in the fields of medicine by discussions and meetings of various kinds supplementing his own reading. In June of this year, the Association sponsored a postgraduate seminar in conjunction with the Medical School. It is planned to carry out such a program throughout the state, engaging where possible the help of local men. Lectures on atomic warfare and civilian defense against it have been made available to all societies. A seminar on Therapy has been jointly sponsored by the Association and the Medical School and will be held in October on the day following the Annual Meeting.

Most practitioners of medicine have little time and less stomach for didactic lectures. Nevertheless, many are willing to take time to go to other communities for seminars and conferences which they consider worth while. In their own communities they are frequently kept away by their daily duties. It is recommended that local men be used in these courses provided they are available and fully competent. The factors of courtesy and the very substantial one of prestige should not be disregarded. Men from teaching centers must for the most part be depended upon for this work. Such programs should be offered to all but not forced upon any county societies. A system whereby clinico-pathological conferences could be held periodically throughout the state might be feasible.

The Medical School is undertaking a series of telephone programs in which it is proposed that the Association should have the responsibility of supplying telephone facilities and publicity, while the Medical School provides the programs. This method has been utilized in some parts of the state already and is being used in Indiana. The advantages of such a method of teaching should not blind us to the fact that a surfeit of spoon feeding from central sources may be demoralizing. It might impair the initiative of county societies for organizing and improving their own programs. Stimulation of county societies to educate themselves cannot be replaced by anything that can be brought to them from without. This problem should be considered carefully and at length by our Association.

Respectfully submitted,  
COMMITTEE ON MEDICAL EDUCATION

/s/ Thornton Scott  
Thornton Scott, Lexington, Chairman  
Malcolm D. Thompson, Louisville  
Guthrie Y. Graves, Bowling Green  
Herbert L. Clay, Jr., Louisville  
J. Murray Kinsman, Louisville  
W. W. Nicholson, Louisville

SPEAKER HOUSTON: We are ready for the report of the special committee, Committee for the Centennial Meeting, Dr. Sam Overstreet.

DR. OVERSTREET: The report is filed.

#### REPORT OF COMMITTEE FOR CENTENNIAL MEETING TO THE 1951 SESSION OF HOUSE OF DELEGATES

This Committee was charged with the responsibility of preparing a fitting program for the Centennial of the Kentucky State Medical Association. A sincere effort has been made to prepare and assemble a worthy program of celebration. It is submitted to you and to the members of the State Medical Association for your pleasure and approval.

Respectfully submitted,  
COMMITTEE FOR CENTENNIAL MEETING

/s/ Sam A. Overstreet  
Sam. A. Overstreet, Louisville,  
Chairman  
Richard R. Slucher, Buechel  
W. Clark Bailey, Harlan  
William R. McCormack, Bowling Green  
J. Duffy Hancock, Louisville  
Emmet F. Horine, Brooks  
R. Haynes Barr, Owensboro

SPEAKER HOUSTON: Dr. Overstreet's report is filed and referred to Reference Committee number 3.



The Committee on Diabetics, Dr. Morse, Louisville.

DR. MORSE: The report has been filed, but since this is the first time that your Association has attempted to make a Diabetic Detection Drive, I would like to urge every delegate here to put his shoulder to the wheel and help this get started. There is always a lot of inertia, and I would appreciate it if you would get behind this drive and put it over.

#### **REPORT OF DIABETIC COMMITTEE TO THE 1951 SESSION OF HOUSE OF DELEGATES**

Your committee has planned for a Diabetic Detection Drive throughout the state of Kentucky, November 11-17, 1951, in cooperation with the American Diabetes Association.

Every County Medical Society is to organize and conduct the Diabetes Detection Drive in its own county with a committee appointed by the County Medical Society President.

Each member of the County Medical Society will be sent a double postal card with a return address to signify his intention of cooperating with the drive or state his objection. Failure to return the card will signify agreement.

Your state committee will make available to each county whatever literature is available, releases for local newspapers, and radio and TV scripts if obtainable.

The Ames Company will supply the Clinitest material without charge to all physicians, hospitals and laboratories that run urine sugar tests which will be free to the patients.

Druggist, Dental and Hospital Associations will be asked to join in support of the drive.

We will urge each County Medical Society to have speakers appear before such organizations as Rotary, Kiwanis, Lions, Optimists, Chambers of Commerce, Woman's Clubs, Parent-Teachers Associations, etc.

We want to attempt to make everyone diabetes conscious during the week of the drive so that we may uncover that million of unknown diabetics that is believed to be among us in the United States and going without treatment or care.

All persons found to have positive urine sugars will be referred to their own physician to determine by further tests whether they have diabetes.

At the end of the drive, each county will be asked to report the number of tests run and the number of positive sugars found.

We have asked each member of the committee to find the consensus of opinion among his colleagues who are interested in diabetes about the organization of the Kentucky Dia-

betes Association as an affiliate of the American Diabetes Association. It is felt that this organization would be very helpful in bringing to the Kentucky State Medical Association's Annual Meeting an outstanding man in diabetes, promote a summer camp for diabetic children, and other worthwhile things in a diabetic way.

Respectfully submitted,  
DIABETIC COMMITTEE

/s/ Carlisle Morse  
Carlisle Morse, Louisville, Chairman

George N. Burger, Covington  
William P. Hall, Paducah  
Frank H. Moore, Bowling Green  
Martin Palmer, Hazard

SPEAKER HOUSTON: Thank you, Dr. Morse. If there is any discussion on it, go to the Reference Committee number 3 tomorrow at two o'clock.

The Committee on Emergency Medical Service, Dr. Imes of Louisville. Dr. Imes' report is in. It's been referred to Reference Committee number 3.

#### **REPORT OF COMMITTEE ON EMERGENCY MEDICAL SERVICE TO THE 1951 SESSION OF HOUSE OF DELEGATES**

The Committee on Emergency Medical Service has had an active year. All of our efforts have been directed toward carrying out the national civilian defense program.

It has been our privilege to cooperate with the civil defense organizations, working directly with P. M. Crawford, M. D., Deputy Director of Health Services for Civil Defense of the State of Kentucky.

A dinner meeting was held on the eve of the County Society Officers Conference early in the year. The purpose of the meeting was to set the policy of the committee and outline the year's activities.

In order that the committee might have the benefit of what was happening elsewhere, we had as our guests Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, who told us of the experiences of his state in this matter; Elmer L. Henderson, M. D., who was President of the American Medical Association at the time; and George F. Lull, M. D., Secretary and General Manager of the American Medical Association. Also with us were Sam A. Overstreet, M. D., Dr. Crawford and William Lamb, M. D., of the Louisville-Jefferson County civil defense setup.

After discussion, it was agreed to ask each county medical society to appoint an emergency medical service committee and send

names of the committee members to the Headquarters Office. Each committee would be supplied with material designed to make their activity productive. A total of 25 counties have submitted the names of their county committees.

Dr. Crawford has been most helpful in providing material for the counties to use. The counties were divided into three different categories, and aids were designed to be suitable for each category.

In addition, our committee has been active in organizing and promoting courses in the treatment of atomic illness. This course runs for three hours and includes two lectures, of an hour each, and a film. It is offered to second and third class cities. The course has been given in three localities and two other courses are tentatively planned for this fall.

The committee has met with some resistance within the profession which holds that Kentucky does not contain but one or two targets of military significance, so why should the rest of the state bestir itself. Our committee agrees that it is unlikely that few, if any, targets of military significance to the enemy are in Kentucky. However, our committee wishes to point out that one properly placed A-Bomb in Cook County would render useless 70% of the hospital facilities in Chicago.

This being true, consider what well-placed bombs in Louisville and Cincinnati would do to hospitals. It would then be up to Kentucky to accept its share of taking care of refugees, and the medical profession would have to treat them. If we are not trained and equipped to take care of these victims properly, then we will be held accountable.

I am grateful to the members of my committee for their support and cooperation.

Respectfully submitted,  
COMMITTEE ON EMERGENCY  
MEDICAL SERVICE

/s/ Pat R. Imes

Pat R. Imes, Louisville, Chairman  
Guthrie Y. Graves, Bowling Green  
Orion L. Higdon, Paducah  
W. Mountjoy Savage, Maysville  
Leland E. Payton, Lynch  
Francis M. Massie, Lexington

SPEAKER HOUSTON: Committee on Hospitals, Dr. S. H. Flowers of Middlesboro.

DR. FLOWERS: Mr. Chairman, the report has been filed and is in.

#### REPORT OF COMMITTEE ON HOSPITALS TO THE 1951 SESSION OF HOUSE OF DELEGATES

The Committee on Hospitals wishes to submit the following report:

The Committee on Hospitals wishes to call most urgently to the attention of the members of the Kentucky State Medical Association the bill which is being presented to the Legislative Committee of the Kentucky State Legislature for their perusal and probable passage at the next biannual session of the Legislature. This bill has been made up and also approved by the Legislative Committee of the Kentucky State Medical Association; and due to the fact that this committee has backed this bill so forcibly, it has not been necessary for the Committee on Hospitals, as such, to have any special meeting concerning the bill.

However, your chairman did attend a meeting of the joint committees for a hearing on this bill (both a public and later a private hearing), at which time the Chiropractors Association of the state objected seriously to a clause in the bill which would provide regulation for hospitals which might be set up in the State of Kentucky by members of the Chiropractic Association. In so far as could be told, the only objection which the Chiropractic Association could present to the bill was the fact that they would be brought under the regulation of the State Board of Health, and the hospital regulations set up by the committee to be established by the proposed bill as relates to a hospital which might be established under the management of a chiropractor or member or members of the Chiropractic Association.

Your Committee on Hospitals wishes to urge your consideration of this bill and your support of it personally, and wishes to urge you as individuals to contact your state senators and representatives requesting that they support this bill when it is brought before the Legislature. It is not known by this committee at this time whether or not public hearings will be called for on this bill when it does come before the Legislative session, but this seems quite probable.

There have been no other matters brought to the attention of the Committee on Hospitals as requiring any action by this committee during the twelve month period passed.

Respectfully submitted,  
COMMITTEE ON HOSPITALS

/s/ S. H. Flowers

Sam H. Flowers, Middlesboro,  
Chairman

Joseph C. Bell, Louisville  
B. Earl Caywood, Danville  
Rankin C. Blount, Lexington

SPEAKER HOUSTON: You have Dr. Flowers' report. It has now been referred to Reference Committee number 3 for study.

The Kentucky State Advisory Committee to Selective Service, Dr. A. Clayton McCarty of



Louisville. The report is here and is being referred to Reference Committee number 3.

**REPORT OF KENTUCKY STATE ADVISORY  
COMMITTEE TO SELECTIVE SERVICE  
TO THE  
1951 SESSION OF HOUSE OF DELEGATES**

While the Kentucky State Advisory Committee to Selective Service was neither authorized nor appointed by the Kentucky State Medical Association or any part thereof, said committee is keenly appreciative of the support which has been received throughout the entire State Association. It is a pleasure and a privilege, therefore, to make a report to the House of Delegates concerning the committee's activities during the past year, and to express again our appreciation for the work which has been done by all. This is particularly true of Mr. Joe Sanford and those at the Headquarters Office, as well as the councilors and others throughout the state.

Due to the international situation, many Kentucky doctors have been called into service. It has been the function and earnest effort of the Advisory Committee to try to see that doctors were called, not only according to the law, but according to the needs of our Commonwealth. In some cases, this caused considerable confusion, some hard feelings, and the bringing to bear of political influence. It should be said at this point that we have had excellent cooperation from Colonel Solon Russell and his associates at the Kentucky State Selective Service Headquarters, and, also from Colonel Owen Durham and his associates at the Kentucky Military District. We have had less close connection with the Naval authorities, but certainly we have had no dissatisfaction in our dealings with this excellent department.

As of the present moment, most all doctors in Priority I are either in service, deferred for six months to a year to carry on essential work, or have received Reserve commissions and will be called in due time. According to the latest reports from Second Army Headquarters, under which we operate, no more Kentucky doctors will be needed before December 1, 1951 (excepting, of course, those Reservists already mentioned in Priority I who may be called up at appropriate times). It is estimated that Priority II physicians will be called during the early part of 1952, and Priority III physicians will be called during the latter part of the same year. If this be true, Priority IV physicians will not be under consideration before 1953. Of course, all of these estimates are subject to man-power changes and demands. An important meeting of our committee will be held in Louisville on Sun-

day, September 30. Many important considerations, matters, and individuals are on the agenda; if any are of special interest, a further report will be made.

Our committee would appreciate it if those counties which have not appointed local Advisory Committees would do so at once. In this way, most decisions can be made at the local level, which is the proper place for same.

Our committee wishes again to express its appreciation of the fine cooperation which we have received from all Kentucky physicians called upon in its work.

Respectfully submitted,

**KENTUCKY STATE ADVISORY  
COMMITTEE TO SELECTIVE  
SERVICE**

/s/ A. Clayton McCarty

A. Clayton McCarty, Louisville,  
Chairman

J. Duffy Hancock, Louisville, Vice-  
Chairman

Charles E. Billington, Paducah

Glenn U. Dorroh, Lexington

R. Arnold Griswold, Louisville

L. O. Toomey, Bowling Green

John L. Walker, D. D. S., Louis-  
ville, Sub-Chairman

Frank W. Jordan, D. D. S., Louis-  
ville

E. C. Hume, D. D. S., Louisville

**SPEAKER HOUSTON:** The K.S.M.A. Dental Committee, Dr. John J. Wolfe of Louisville. His report is here and referred to Reference Committee number 3.

**REPORT OF K.S.M.A. DENTAL COMMITTEE  
TO THE  
1951 SESSION OF HOUSE OF DELEGATES**

The purpose of this committee is presumed to deal with matters of interest to both dental and medical professions, to promote mutual understanding and harmony, and last but not least, to serve as a vehicle for mutual education.

Informal meetings with individual members of the committee and finally a joint meeting were held. The following matters were discussed.

**1. ADMISSION OF DENTISTS TO MEDICAL MEETINGS:**

It was the desire of many of the dentists to be permitted to attend medical meetings. The dental members of the committee were not desirous of holding office or exerting influence in the medical association. It was the opinion of the committee that the matter should be considered at the next State Medical Meeting and a motion to that effect was carried.

It is the recommendation of this committee that the Kentucky State Medical Association consider the changing of its By-Laws to permit members in good standing of the Kentucky State Dental Association to become associate members of the State Medical Association with the privilege of attending scientific meetings and discussing the papers. This membership would not permit the participant to hold office or vote and would carry a fee necessary to cover the clerical help in keeping records.

## 2. STIMULATION OF INTEREST IN MEDICO-DENTAL SUBJECTS:

Some positive steps should be taken to stimulate interest in subjects of mutual concern among medical and dental students. One possibility is an essay contest open to senior medical and dental students on a subject such as Focal Infection. This need not be an original research, but a review bringing the subject up to date. The winner of the contest would be invited to read the essay at the Annual State Medical Meeting. A prize for the best essay also might be considered. Rules for the essay contest would be worked out by a small subcommittee which would include the Deans of the Medical and Dental Schools. It is felt that this approach might call wide attention to the need for more integration in the two professions.

## 3. LEGISLATIVE:

With the present wide scale use of antibiotics dentists find the necessity of administration of these and other drugs by intramuscular route. Some injections occasionally result in complications, either immediate or late reactions, and abscess formation, etc. The administration of sodium pentathol was also discussed. Judge L. R. Curtis pointed out that no definite ruling had been made against the use of such drugs by dentists, and it appeared that there was considerable ambiguity in the laws regulating dental practice. It was not known for example, how far beyond the oral cavity a dentist could extend his treatments. Could he treat lesions of the skin of the face or neck, etc? It was stated even that dentists were entitled to sign death certificates. With this uncertainty it is obvious that the entire matter calls for careful review and new legislation, aimed to define clearly the scope of dental practice in conformity with the present training in dentistry, as much as anything, for the protection of the dentist himself.

## 4. PUBLIC EDUCATION:

The dentist reaches a large number of people who rarely find their way to the doctor's office. Thus public education in their welfare by posters, etc., would reach larger numbers via the dental office. The dentists should be in-

vited to post notices and pamphlets in their waiting rooms on the occasion of such programs as Diabetic Detection or Cancer Detection. This was agreed upon by the dental members who have kindly undertaken to promote the present diabetes detection campaign.

It is felt that the Medical-Dental Committee should be able to serve a real purpose in articulating the activities of the medical and dental organizations. It is hoped that the suggestions submitted herewith will be acted upon, for such action will encourage further efforts on its part.

Respectfully submitted,  
K.S.M.A. DENTAL COMMITTEE  
/s/ John J. Wolfe  
John J. Wolfe, Louisville, Chairman  
Allen L. Cornish, Lexington  
Thomas J. Crume, Jr., Owensboro

SPEAKER HOUSTON: K.S.M.A. Pharmacy Committee, Dr. Ben H. Hollis, Louisville. Dr. Hollis's report is in and is being referred to Reference Committee number 3.

## REPORT OF K.S.M.A. PHARMACY COMMITTEE TO THE 1951 SESSION OF HOUSE OF DELEGATES

There was no business referred to the Pharmacy Committee this year. The Chairman met with Mr. Sidney Passamaneck, but there was no business that required the calling of a joint meeting between the pharmacists and the members of this committee.

It is recommended that the Committee continue to be organized and that it meet with the pharmacists again this year.

Respectfully submitted,  
K.S.M.A. PHARMACY COMMITTEE  
/s/ Ben H. Hollis  
Ben H. Hollis, Louisville, Chairman  
Thornton Scott, Lexington  
W. Keith Crume, Bardstown  
Hugh L. Houston, Murray

SPEAKER HOUSTON: The Committee on Legislation—I have filed that report. It is now being referred to Reference Committee number 3 for study.

## REPORT OF LEGISLATIVE COMMITTEE TO THE 1951 SESSION OF HOUSE OF DELEGATES

The Legislative Committee was created by the Council and the chairman was empowered to name its members.

The purpose of the committee is to study legislation before the Kentucky General Assembly and to plan a legislative program on health and welfare problems in our state. Your committee has accepted the State Board of



Health as the legal, statewide agency interested in health and welfare, and has worked with Bruce Underwood, M. D., State Health Commissioner, to formulate a legislative program. This program is designed to improve the health of our people and coordinate the efforts of our profession with the public agencies now existent.

The chairman appointed the following members of the Association to serve on this committee: Guy Aud, M. D., Louisville; Haynes Barr, M. D., Owensboro; B. B. Baughman, M. D., Frankfort; Rufus Alley, M. D., Lexington; Charles B. Stacy, M. D., Pineville and Clark Bailey, M. D., Harlan. Bruce Underwood, M. D., Secretary and General Manager of the Association, will act as secretary and ex-officio member of the committee.

Because of practical politics, your committee wrote three letters to the profession concerning candidates to be considered in the August Primary who had been loyal, through the years, to the program of the medical profession at Frankfort. Only statement of facts was made and no other activities in their behalf were exercised. The doctors in the areas affected were thus contacted, and their decisions as to local effort were considered satisfactory.

The committee is bi-partisan, and interests of all candidates who might effect our program are taken under consideration by the central office.

The committee has endeavored to activate all physicians to become more interested in political life and governmental activities. All doctors should vote and use their influence for men to public office who will sponsor and support sound legislation in behalf of health and welfare matters. Each doctor should know his representative and senator, and his scientific knowledge should aid these public servants in their legislative duties. We, as a committee, insist on an honest effort by the profession to aid our duly elected public servants in their duties. Politics is the science of government and need not be below the dignity and interest of every citizen of the Commonwealth. The evils of political activities are due to neglect of the science by the leading thinkers among our people. As medicine slips under public control, physicians should make sure that medical, surgical and hospital personnel are kept on a high professional level and the quality of the service does not decline.

The committee's life has been short and its activities have been few, but the basic philosophy of our entering into these activities is new, perhaps controversial, and needs serious thought of this House of Delegates. May the

Reference Committee receiving this report have full discussion on the committee's activities to date and receive recommendations for our future activities.

Respectfully submitted,  
LEGISLATIVE COMMITTEE

/s/ Hugh L. Houston  
Hugh L. Houston, Murray,  
Chairman  
Guy Aud, Louisville  
B. B. Baughman, Frankfort  
Charles B. Stacy, Pineville  
Rufus C. Alley, Lexington  
R. Haynes Barr, Owensboro  
Clark Bailey, Harlan

The Board of Directors of McDowell Memorial Foundation, Dr. Vance of Lexington.

DR. VANCE: Mr. Chairman, the report is in and it is ready to be filed.

#### **REPORT OF BOARD OF DIRECTORS OF McDOWELL MEMORIAL FOUNDATION TO THE 1951 SESSION OF HOUSE OF DELEGATES**

Since the 1950 report of the Committee on the McDowell Memorial to the 1950 session of the House of Delegates was made, the McDowell Memorial Foundation was incorporated and a considerable amount in donations has been received. These have been in the form of memberships in the Foundation for one year at \$2.00, 15 years at \$25.00, and life memberships for \$100.00. Already more than \$1000.00 in donations were made in Danville. For the summer months we have procured a custodian and have paid her a salary of \$100.00 a month, and this year we have charged thirty-five cents each for tourists going through the house. Of course, we will have taxes to come out of that, but we thought after our experience last year it was better to charge a small fee than to expect guests to make donations. A new folder about the McDowell Memorial has been published and sent to many over the country, and this was written by Emmet F. Horine, M. D. The letter to be sent to the State Medical Association members and then over the country has not been published, but has been written. Much furniture has been bought and placed in the home. This has all been approved by the Furniture Committee, consisting of Mrs. W. O. Bullock, Chairman, and Mrs. Nelson, Mrs. Goddard and Mrs. Evans.

The Woman's Auxiliary of the Jefferson County Medical Society is going ahead with the furnishing of their room and have spent most of the money they have collected on that. The Woman's Auxiliary of the Fayette County Medical Society has had donations, and the county society has voted to donate enough

for the Woman's Auxiliary to finish the furnishing of their room.

As you probably know, Dr. and Mrs. E. L. Henderson donated \$1000.00 and as much more as necessary to furnish the Doctor's office. Several other donations have been made to that fund. Mr. and Mrs. F. Zorniger, of Wilmore, made donations of furniture amounting to about \$2200.00 and that furniture has been placed in the home.

The Council of the State Medical Association gave the Board of Directors of the Foundation \$1000.00 for the upkeep and repairs of the home. Inasmuch as we converted the furnace we had to gas and the burner cost about \$260.00 or more and other things had to be done, we have not had enough money to do all the repairs needed. The fence needs to be rebuilt and the roof needs fixing. There are a number of smaller things to be done about the house, but we have to carry out the most urgent ones and have put off the others until we have more money.

Much consideration has been given the Apothecary Shop. It has been found out that the original Apothecary Shop extended only about one-third of the present one along the north side of the house. It has been suggested that the rest of the Apothecary Shop be torn down and the front end of the original shop be rebuilt. We could then use the shop for keepsakes and mementoes, postal cards and anything we would like to sell. In doing that, the home itself would be protected against fire, and the garden could be extended around the back end of the house to this open space which would be left. Perhaps one, or some, of the drug houses could be solicited for donations to this. One of the drug houses has already given us a small donation for the general fund.

Mrs. Bailey, President of the Woman's Auxiliary, has announced that they plan to show pictures of the life of Ephraim McDowell at the State Medical Association meeting in October. This should be very interesting to the membership of the Association.

We were allowed a booth at the exhibits of the American Medical Association at Atlantic City. Mrs. Walker Owens had charge of this and showed some pictures of the life of McDowell. She talked with people about the home and distributed folders about it. Mrs. Owens did not solicit any funds, but she found a great many people were interested in the organization and the worthwhile project that the State Medical Association has undertaken.

The Little Garden Club, of Danville, has done a splendid job for several years on the garden at the McDowell House and has spent a total of \$402.62 on labor, supplies, landscap-

ing, planting and purchase of shrubs from 1948 to 1951. We feel that they have done splendid work. We are very much indebted to them for their services and donations and wish to extend to them many, many thanks.

The receipts and disbursements of the McDowell Foundation will be given you in detail by Mrs. Walker Owens, but I would like to call to your attention that in the furniture account of August 15, 1951, we had a balance of \$1709.93. Up to that time we had cash contributions of \$5542.35. In the repairs and supplies account which was forwarded September 1, 1950, a balance of \$33.05 was shown. I would like to summarize Mrs. Owens' report as follows:

Oct. 1, 1947 to Sept. 30, 1948	
Furniture purchased .....	\$ 1,505.00
Oct. 1, 1948 to Sept. 30, 1949	
Furniture purchased .....	2,620.00
Oct. 1, 1948 to Sept. 30, 1949	
Furniture donated .....	600.00
Oct. 1, 1949 to August 1, 1950	
Furniture purchased .....	1,968.00
Oct. 1, 1949 to August 1, 1950	
Furniture donated .....	1,840.00
Aug. 1, 1950 to August 1, 1951	
Furniture purchased .....	4,586.40
Aug. 1, 1950 to August 1, 1951	
Furniture donated .....	410.00
Total purchases and donations ..	\$13,529.40

We thought perhaps we would get the McDowell Memorial entirely furnished by this year, but it has not been possible. However, we believe we have progressed more this present year than any time previously.

The Board of Directors still believes that eventually the McDowell Memorial will become a paying proposition and be self-supporting, so that we might have a permanent custodian and guides. We certainly hope that the Woman's Auxiliary will continue in their work, and we believe this committee should be made a permanent one, at least until the McDowell Memorial is furnished completely and in running order. We think that this committee has done a splendid job, and we cannot compliment and thank them enough for their efforts.

This property belongs to the Kentucky State Medical Association—it is their baby and perhaps the only one they have, so we feel that they should give some support to its upkeep and running. We would respectfully ask that the House of Delegates of the Association continue the donation for the upkeep of this property which they made this year. Better still, if they would increase it to \$1500.00, your com-



mittee would have a much easier time and the place would be much better kept up.

Respectfully submitted,

**BOARD OF DIRECTORS OF MC-DOWELL MEMORIAL FOUNDATION**

/s/ Charles A. Vance

Charles A. Vance, Lexington,  
Chairman

J. Rice Cowan, Danville

George M. McClure, Danville

Emil Novak, Baltimore, Maryland

Thomas Meredith, Harrodsburg

Russell Starr, Glasgow

Laman A. Gray, Louisville

Irvin Abell, Jr., Louisville

E. Murphy Howard, Harlan

**SPEAKER HOUSTON:** I now refer the report to Reference Committee number 3 for study.

The Committee on Nurse Training, Dr. Johnson, Louisville. Dr. Johnson's report is in. It is now being referred to Reference Committee number 3.

**REPORT OF COMMITTEE ON NURSE TRAINING TO THE 1951 SESSION OF HOUSE OF DELEGATES**

The purpose of this committee is to concern itself with interest in the Association and in aiding, whenever possible, the improvement of nursing care and the procurement of more nurses in the state of Kentucky.

Shortly after this appointment was received, the chairman of the committee, by personal interview, made contacts with the leading members of the nursing profession in the city and the surrounding territory and found that throughout the cooperation was most satisfactory.

Notes have been made from the meetings of the Nursing Council. The nursing profession has been divided into fifteen divisions. At the last meeting, held on February 27, 1951, in the Assembly Room of the State Board of Health, a discussion of the work of the different departments was brought out. The Nursing Department and the Department of Civilian Health presented a very excellent program towards bringing up the Civilian Defense for the state of Kentucky.

Miss Campbell gave a report on the improvement of the nursing service in Kentucky. Miss Necker, who is chairman of the State Nursing Education Service, stated that their work will be continued when the findings of the survey, which is being done by Miss Applegate throughout the state, is completed. After this, the actual needs of the nursing situation were

brought forth. Miss Boyd discussed the field of practical nurses and the work that is being done for this, and stated that there have been two schools of practical nursing started. They are also giving examinations to practical nurses over the state.

Miss Pierce is giving a Home Nursing Class in Civilian Defense for the division of teachers.

Mrs. Bach, the representative from the Kentucky State Medical Association Woman's Auxiliary, gave an outline of their work in establishing a scholarship to encourage women to take up nursing. She discussed the possibility of getting contributions for such scholarships.

The meeting ended with a definite note of encouragement as to the progress attained by the organization. A program was outlined for the continuation of this good work. The nurses show a very cooperative spirit, and this is helpful in the improvement of the nursing situation in Kentucky. I have nothing but commendation for this body of excellent working women and cooperative group.

Respectfully submitted,

**COMMITTEE ON NURSE TRAINING**

/s/ W. O. Johnson

W. O. Johnson, Louisville, Chairman

Charles B. Stacy, Pineville

W. Vinson Pierce, Covington

**SPEAKER HOUSTON:** The Professional Relations Committee, Dr. J. Watts Stovall, Grayson. Dr. Stovall's report is in. It is being referred to Reference Committee number 3.

**REPORT OF PROFESSIONAL RELATIONS COMMITTEE TO THE 1951 SESSION OF HOUSE OF DELEGATES**

The Professional Relations Committee of the Kentucky State Medical Association wishes to report that it has been active during the past year and its efforts have been productive of success.

Two changes were made at the beginning of the year: (1) It was felt that the title, "Grievance Committee," might have a tendency to suggest conditions that did not exist and might otherwise lead people to complain unnecessarily. After careful discussion and consideration the committee recommended to the Council that its name be changed from "Grievance Committee" to "Professional Relations Committee." The Council accepted this recommendation.

(2) When the committee was activated the directive stipulated that it should be made up of the most recent five past presidents of the

State Association, with the newest past president serving as chairman. It was later decided the chairman of the committee could act with more wisdom if he had the experience of several years service on the committee, and that the committee member serving his fifth year should automatically be the chairman. This motion was made by Hugh L. Houston, M. D., the latest past president to serve on the committee. This was presented to the Council in the form of a recommendation and it was also accepted.

Many of the cases this committee is called on to consider endure over a period of many months. We have some cases that were held over from the 1949-50 year—others have been completed.

The most common allegations against the members of the profession are overcharging, failure to make calls, failure to properly explain statements, and rendering services without the consent of the patient.

The committee was given a new assignment by the Council at its May 10 session. The committee was asked to investigate those physicians whose conduct or practice is alleged to be not in the best interests of the public or profession. The committee will then investigate the matter and report to the Council which will, in turn, recommend a course of action to the State Board of Health. The Council's thinking in this matter was that the medical profession should make some effort to cooperate with the State Board of Health in policing the profession.

I want to thank the other members of my committee for their cooperation and industry in carrying on the work of this committee this year.

Respectfully submitted,

PROFESSIONAL RELATIONS COMMITTEE

/s/ J. Watts Stovall

J. Watts Stovall, Grayson, Chairman

E. W. Jackson, Paducah

Guy Aud, Louisville

Charles A. Vance, Lexington

Hugh L. Houston, Murray

**SPEAKER HOUSTON:** The Committee to Study the Constitution and By-Laws, Dr. Aud of Louisville.

**DR. AUD:** Mr. Chairman, the report has been submitted and also sent to every county society in order that they might instruct their delegates how to vote on the changes in the Constitution.

## REPORT OF THE COMMITTEE TO STUDY THE CONSTITUTION AND BY-LAWS TO THE 1951 SESSION OF HOUSE OF DELEGATES

The committee has carefully studied the Constitution and By-Laws of the Association. We believe the Constitution and By-Laws deserve continued study and that they should be continually revised in the light of changing conditions. We recommend the following proposed changes for consideration at the 1951 meeting of the House of Delegates. We urge all physicians and all component societies to carefully study our proposals and to express themselves to their elected delegates. We should be pleased to have your comments regarding these proposals or any suggestions you may have for additional changes.

Respectfully submitted,

COMMITTEE TO STUDY THE  
CONSTITUTION AND BY-  
LAWS

/s/ Guy Aud

Guy Aud, Louisville, Chairman

R. Haynes Barr, Owensboro

Charles B. Stacy, Pineville

Hugh L. Houston, Murray

Bruce Underwood, Louisville

### Chapter I, Section 2, of the By-Laws

Change the title and the first sentence to read as follows:

Section 2. Active Members. "Active members shall comprise the active members of the component medical societies." (Note: This will permit qualified negro physicians to be members of the Kentucky State Medical Association and the American Medical Association provided they are members of a component society as provided in Chapter XII, Section 4, of the By-Laws. Each county society is thus free to accept or reject negro members as may be desired. If negro physicians are not accepted by their county society, membership in the statewide component society will entitle them to membership in the Kentucky State Medical Association.)

### Chapter VI, Section 2, of the By-Laws

Change the first sentence to read as follows:

"The President-Elect shall be a member of the Committee on Scientific Assembly."

### Chapter VI, Section 6, of the By-Laws

Change the last sentence of this section to read as follows: "Either the Treasurer, the President, the Secretary, or the Executive Assistant is authorized to pay money out of the treasury as authorized by the Council or the House of Delegates. All four officials shall give bond in the amount determined by the Council. The Treasurer shall subject his ac-



counts to an annual audit under the direction of the Council. He shall render an annual account of his doings and the state of all Association funds."

#### Chapter VII, Section 1, of the By-Laws

Revise to include the immediate Past President as an ex-officio member of the Council with a right to vote.

#### Chapter VII, Section 1, of the By-Laws

Change the next to the last sentence in this section to read as follows: "The Executive Committee shall consist of the President, the Chairman of the Council, the Secretary, and two Councilors to be elected annually by the Council."

#### Chapter VII, Section 5, of the By-Laws

Change the last sentence to read as follows:

"Such communications shall be signed by the President of the Association and the Chairman of the Council as such."

#### Chapter VIII, Section 1, of the By-Laws

Change to read as follows: "Section 1. The Standing Committees shall be as follows:

- A Committee on Arrangements
- A Committee on Scientific Assembly
- A Committee on Public Relations
- A Committee on Medical Service
- A Committee to Study Constitution and By-Laws

A Medico-Legal Committee and such other committees as may be necessary. The Headquarters Office at 620 South Third Street, Louisville 2, Kentucky, shall be the headquarters for all committees and activities of the Association except as may be specifically authorized by the Executive Committee. Committees shall be appointed by the President of the Association in conference with the Secretary unless otherwise specified. The President and the Secretary shall be ex-officio members of all committees except as otherwise specified."

#### Chapter VIII, Section 2, of the By-Laws

Change the first sentence to read as follows:

"Section 2. The Committee on Arrangements shall consist of as many members and subcommittees as are appointed by the President of the Association."

#### Chapter VIII, Section 3, of the By-Laws

Change the first three sentences to read as follows: "The Committee on Scientific Assembly shall consist of five members. The President of the Association shall be a member and Chairman of the Committee. The President-Elect shall be a member of the Committee. The Secretary of the Association shall be a member and Secretary of the Committee. The President of the Association shall appoint one member for a two-year term."

#### Chapter VIII, Section 4, of the By-Laws

Change the first five sentences to read as follows: "The Committee on Public Relations shall consist of five members appointed by the Council of the Association. The members shall be appointed for a term of three years each, which shall be staggered in so far as possible. The Chairman of the Committee shall be designated by the Council. Under the direction of the Council it shall represent the Association in securing and enforcing legislation in the interest of Public Health and scientific medicine."

#### Chapter VIII, Section 5, of the By-Laws

Change the first sentence to read as follows: "The Committee on Medical Service shall consist of five members appointed by election of the Council. The terms of each member shall be for three years and shall be staggered in so far as possible. The Council shall annually designate the Chairman of the committee."

#### Chapter VIII of the By-Laws

Add the following section: "Section 7. The Committee to Study the Constitution and By-Laws shall make a constant study of the Constitution and By-Laws. The committee shall annually make a recommendation concerning changes which it feels should be made in order to keep the Constitution and By-Laws in line with changing conditions and circumstances."

#### Chapter IX, Section 3, of the By-Laws

Change the section to read as follows: "All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have the prior approval of the Council before they can become effective."

#### Chapter XII, Section 4, of the By-Laws

Change the first sentence of the section to read as follows: "Only one component society shall be chartered in any county except that the House of Delegates may issue a charter to one state-wide society of worthy Negro physicians who are not members of any county society. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky State Medical Association."

#### Chapter XII, Section 12, of the By-Laws

Change this section as follows: "At the time of the annual election of officers each component society shall elect a delegate or delegates to represent it in the House of Delegates of this Association in the proportion of one delegate to each twenty-five members or major fraction thereof and the secretary of the society shall send a list of such delegates to the Secretary of this Association on or before April 1 of each year."

**SUPPLEMENTARY REPORT OF THE  
COMMITTEE TO STUDY THE CONSTITU-  
TION AND BY-LAWS TO THE  
1951 SESSION OF HOUSE OF DELEGATES**

The Committee wishes to submit this supplementary report which provides for a signature and a counter-signature for all vouchers of the Association. We believe this to be a desirable change. We wish to change our recommendation concerning Chapter VI, Section 6, of the By-Laws and amend it to read as follows:

Chapter VI, Section 6, of the By-Laws

Change the last full sentence to read as follows: "All vouchers of the Association shall be signed by the Secretary or his Executive Assistant and shall be counter-signed by the Treasurer of the Association. Under unusual circumstances, when one or more of the above named officials are not readily available, the President of the Association or the Chairman of the Council is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in any amount to be determined by the Council. The Treasurer shall subject his accounts to an annual audit under the direction of the Council. He shall render an annual account of his doings and the state of all Association funds."

Respectfully submitted,

**COMMITTEE TO STUDY THE  
CONSTITUTION AND BY-LAWS**

/s/ Guy Aud

Guy Aud, Louisville, Chairman

R. Haynes Barr, Owensboro

Charles B. Stacy, Pineville

Hugh L. Houston, Murray

Bruce Underwood, Louisville

**SPEAKER HOUSTON:** If there's any discussion on this report, please go to that meeting tomorrow at two o'clock. The report is referred to Reference Committee number 3.

The Committee on Training of Ambulance Attendants, Dr. C. C. Howard, Glasgow.

**DR. HOWARD:** The committee has filed its report.

**REPORT OF COMMITTEE ON TRAINING OF  
AMBULANCE ATTENDANTS TO THE  
1951 SESSION OF HOUSE OF DELEGATES**

A committee of the Southeastern Surgical, jointly with a committee from the State Medical Association, have had two meetings with the men who operate ambulances at Mammoth Cave. These have been very helpful in formulating a basic law to train and register all ambulance attendants. I believe we are

on the way to accomplish this much-needed attention to the sick and injured.

Respectfully submitted,

**COMMITTEE ON TRAINING OF  
AMBULANCE TRAINING**

/s/ C. C. Howard

C. C. Howard, Glasgow, Chairman

Gaithel Simpson, Greenville

Carl Norfleet, Somerset

Hugh L. Houston, Murray

Paul B. Hall, Paintsville

J. Duffy Hancock, Louisville

L. H. South, Louisville

C. C. Sparks, Ashland

Charles B. Stacy, Pineville

Robert R. Starr, Glasgow

**SPEAKER HOUSTON:** The report is referred to Reference Committee number 3.

The reports of the advisory committees on medical care, the Committee on Cancer, Dr. Aud.

**DR. AUD:** The report has been submitted.

**REPORT OF COMMITTEE ON CANCER  
TO THE**

**1951 SESSION OF HOUSE OF DELEGATES**

The Kentucky State Medical Association has every reason to be justly proud of the Cancer Control Program that is being conducted in the Commonwealth of Kentucky. It has been through the interest and cooperation of the entire membership of this organization that Kentucky has reached a place of pre-eminence in the cancer field. A sincere commendation is given to the hundreds of volunteers who have staffed the cancer clinics and who have given unreservedly and unstintingly of their time and professional skill.

The Committee on Cancer realizes that the Cancer Control Programs of the American Cancer Society and the State Department would not have progressed as they have if it had not been for the sponsorship and endorsement of the Kentucky State Medical Association.

It is realized that one of our major medical problems is cancer, and that one of the paramount objectives of agencies dealing with the problem is to make every physician's office a cancer detection center. It is only through a close relationship of the family doctor to his patients that the death toll of cancer will be eliminated—because of early diagnosis and successful treatment.

It is highly gratifying to observe that clinical records indicate that more people are reporting to their family doctor each year for early diagnosis and treatment.

The Committee on Cancer wishes to express



its deep appreciation to the State Department of Health, The American Cancer Society and the United States Public Health Service for the magnificent role they have played in the Cancer Control Program of Kentucky. It has been through the leadership of these organizations working jointly with the Kentucky State Medical Association that we have progressed so rapidly in such a short space of time.

### Cancer Control Program in Kentucky

The program of Cancer Control in the Commonwealth of Kentucky is functioning satisfactorily and without duplication of effort by various agencies due to the fact that the programs of the State Department of Health, the American Cancer Society and the Kentucky State Medical Association are discussed thoroughly by a committee representing the three groups. Throughout the year meetings have been held and program planning discussed. Due to this type of cooperation, one group is not duplicating the work of another and through study of program planning each agency is carrying out the functions most adaptable to its specific type of organization. The organizations dealing with the problem of Cancer Control may appropriately take for their motto the words from the Great Seal of the Commonwealth, "United We Stand, Divided We Fall."

### Education

Lay educational programs have been carried on in every county of the Commonwealth during the past year. Literature designed for consumption by the lay public has been distributed and especially developed films on cancer have been shown. It is reasonable to assume that lay groups in Kentucky are more cancer conscious than ever before.

Twenty-four county medical societies had scientific programs presented by the volunteer staffs that accompany the Cancer Mobile.

Three outstanding sound, technicolor films were used extensively by medical groups. These are entitled, "Cancer, Problem of Early Diagnosis," "Breast Cancer," and "Gastro-Intestinal Cancer." These films were developed by the American Cancer Society in cooperation with the United States Public Health Service.

The Professional Speakers' Bureau on Cancer continues to have requests for scientific papers. Fifty-two members of the Kentucky State Medical Association were available to speak on eighteen definite phases of cancer, diagnosis and treatment.

The Fourth Annual Cancer Symposium was held in Lexington, Kentucky, August 16, 1950.

Seven of the nation's outstanding men presented a one-day scientific program.

### Method of Referral to Clinics

A member of the medical profession may refer any medically indigent patient to a cancer clinic for diagnoses and/or treatment. The only requirement is that a statement as to the indigency of the patient be made by the referring physician. A short clinical history must be sent with the patient.

### Clinics

The following cancer diagnostic clinics are being sponsored by the Kentucky State Medical Association, the State Department of Health and the Kentucky Division of the American Cancer Society:

#### Barren County

T. J. Samson Community Hospital, Glasgow, Kentucky  
John W. Meredith, M. D., Director  
Each Friday—8:00 A. M.

#### Bell County

Middlesboro Hospital, Middlesboro, Kentucky  
Sam H. Flowers, M. D., Director  
2nd & 4th Wednesday—10:00 A. M.

#### Boyd County

King's Daughters' Hospital, Ashland, Kentucky  
C. C. Sparks, M. D., Director  
Each Wednesday—10:00 to 11:00

#### Christian County

Ida Chappell Cancer Clinic  
Jennie Stuart Memorial Hospital, Hopkinsville, Kentucky  
Robert Coleman, M. D., Director  
Each Tuesday—8:30 A. M.

#### \*Daviess County

Owensboro-Daviess County Hospital, Owensboro, Kentucky  
Howell Davis, M. D., Director  
Each Thursday—9:00 A. M.

#### Fayette County

Good Samaritan Hospital, Lexington, Kentucky  
J. Farra Van Meter, M. D., Director  
Each Tuesday—1:00 P. M.

#### Henderson County

Methodist Hospital, Henderson, Kentucky  
J. Leland Tanner, M. D., Director  
Each Wednesday—12:30 P. M.

#### Jefferson County

\* Norton Memorial Infirmary, Louisville, Kentucky  
Pat R. Imes, M. D., Director  
Each Wednesday—10:00 A. M.  
Red Cross Hospital, Louisville, Kentucky  
C. M. Bernhard, M. D., Director  
1st & 3rd Friday—10:00 to 12:00

\*Closed as of August 1, 1951

St. Joseph's Infirmary, Louisville, Kentucky  
 Irvin Abell, Jr., M. D., Director  
 Each Thursday—8:00 A. M.  
 Central State Hospital  
 Lakeland, Kentucky  
 Henry B. Asman, M. D., Director  
 1st Wednesday—9:00 A. M.  
 General Hospital, Louisville, Kentucky  
 R. Arnold Griswold, M. D., Director  
 Tuesday—12:30 P. M.—By appointment only  
 Cancer Mobile  
 John B. Floyd, Jr., M. D., Director  
 By invitation

**Kenton County**

William Booth Memorial Hospital, Covington, Kentucky  
 John H. Siehl, M. D., Director  
 1st & 3rd Thursday—9:30 A. M.

**McCracken County**

Riverside Hospital, Paducah, Kentucky  
 R. W. Robertson, M. D., Director

1st & 3rd Wednesday—8:00 A. M.

**Muhlenberg County**

Muhlenberg Community Hospital, Greenville, Kentucky  
 G. L. Simpson, M. D., Director  
 1st & 3rd Tuesday—10:00 A. M.

**Pike County**

Methodist Hospital, Pikeville, Kentucky  
 J. C. Preston, M. D., Director  
 Each Thursday—10:00 A. M.

**Warren County**

City Hospital, Bowling Green, Kentucky  
 G. Y. Graves, M. D., Director  
 Each Wednesday—8:30 A. M.

**Report of Clinic Sessions**

The following report is one that the Kentucky State Medical Association should be very proud to have. It is the result of their volunteer efforts in the interest of cancer. This is based on the medically indigent patients seen in the cancer clinics from July 1, 1950 through June 30, 1951.

COUNTY AND CLINIC	No. of Patients	No. of Doctors	No. of Clinics
<b>Barren County</b>			
T. J. Samson Community Hospital Glasgow, Kentucky .....	319	204	49
<b>Bell County</b>			
Middlesboro Hospital Middlesboro, Kentucky .....	252	91	26
<b>Boyd County</b>			
King's Daughters Hospital Ashland, Kentucky .....	500	239	52
<b>Christian County</b>			
Ida Chappell Cancer Clinic Hopkinsville, Kentucky .....	244	204	51
<b>Daviess County</b>			
Owensboro-Daviess County Hospital Owensboro, Kentucky .....	350	132	46
<b>Fayette County</b>			
Good Samaritan Hospital Lexington, Kentucky .....	1,798	510	52
St. Joseph's Hospital Lexington, Kentucky .....	687	575	52
<b>Henderson County</b>			
Methodist Hospital Henderson County .....	178	161	49
<b>Jefferson County</b>			
General Hospital Louisville, Kentucky .....	1,007	1,155	50
Cancer Mobile Unit .....	1,011	60	19
Norton Memorial Infirmary Louisville, Kentucky .....	395	262	51
Red Cross Hospital Louisville, Kentucky .....	136	159	21
St. Joseph Infirmary Louisville, Kentucky .....	1,241	1,244	51



**Kenton County**

William Booth Memorial Hospital

Covington, Kentucky ..... 555                      203                      24

**McCracken County**

Riverside Hospital

Paducah, Kentucky ..... 185                      120                      24

**Muhlenberg County**

Muhlenberg Community Hospital

Greenville, Kentucky ..... 197                      112                      23

**Pike County**

Methodist Hospital

Pikeville, Kentucky ..... 267                      202                      47

**Warren County**

City Hospital

Bowling Green, Kentucky ..... 131                      253                      34

Total .....	9,453	5,886	721
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**Cancer Registry**

Since the inception of the Cancer Registry in January, 1948, through August 10, 1951, 19,610 clinical histories on patients diagnosed as having cancer have been received and tabulated. The Registry is serving as a reasonably accurate gauge as to the size and magnitude of the cancer problem, its prevalence and trends; it is a valuable media for evaluating the program of cancer control; it is beneficial in statistical and research studies; it is aiding in the evaluating of the present forms of therapy. The State Department of Health is to be sincerely commended for this beneficial adjunct to the cancer program.

The Cancer Registry is now reaching the phase of development when we will be able to use the statistical evaluation in formulating more intensified cancer control programs, etc.

**Tissue Biopsy Service**

The Tissue Biopsy Service continues to be a source of great aid to the medical profession who takes biopsies on medically indigent patients. During the fiscal year, July 1, 1950, through June 30, 1951, 1,037 specimens were submitted for examination to the members of the Kentucky Association of Pathologists.

The Committee on Cancer strongly recommends that more biopsies be taken in making

diagnoses for cancer and feel that this service is of immeasurable assistance in aiding physicians who have a great load of medically indigents.

Respectfully submitted,

**COMMITTEE ON CANCER**

/s/ Guy Aud

Guy Aud, Louisville, Chairman

Jesshill Love, Louisville

John W. Meredith, Scottsville

J. Farra Van Meter, Lexington

**SPEAKER HOUSTON:** The report is in. It is being referred to Reference Committee number 4 for study.

The Committee on Crippled Children, Dr. Fischer, Louisville. The report is in. I will refer it to Reference Committee number 4.

**REPORT OF COMMITTEE ON CRIPPLED CHILDREN TO THE 1951 SESSION OF HOUSE OF DELEGATES**

The Kentucky Crippled Children Commission, the official state agency for the care of white and colored crippled children under twenty-one years of age, reports the following activities for the fiscal year July 1, 1950 to June 30, 1951.

As in our last year's report, we give figures from the preceding year for comparison:

	Fiscal Year 1949-1950	Fiscal Year 1950-1951
Number of examinations at itinerant field clinics .....	1,985	1,990
Number of examinations at regular monthly or bimonthly clinics:		
Ashland .....	487	569
Covington .....	649	672
Lexington		
General Out-Patient Clinics .....	975	1,279
Cerebral Palsy Clinics .....	0	325

	Fiscal Year 1949-1950	Fiscal Year 1950-1951
Louisville		
General Out-Patient Clinics .....	2,453	2,299
Cerebral Palsy Clinics .....	616	427
Total examinations at free orthopedic clinics .....	7,165	7,561
Total visits to doctors' offices for examination .....	1,951	2,238
Total visits to office of special consultants .....	281	313
Total hospital admissions .....	1,858	1,757
Total hospital days .....	74,911	62,794
Total convalescent home days .....	2,202	13,654
Total out-patient cast applications and checks .....	893	1,195
Total out-patient physical therapy treatments (exclusive of cerebral palsy cases) .....	9,208	9,085
Total home visits by county public health nurses and orthopedic public health nurses or the Commission staff .....	1,764	1,354
Referrals to vocational rehabilitation .....	620	469
Cerebral Palsy Program		
Total orthopedic examinations .....	616	752
Total physical therapy treatments .....	2,548	2,841
Total occupational therapy treatments .....	1,344	1,216
Total speech therapy treatments .....	1,212	1,089
Total psychological examinations .....	274	211

The per capita cost of treatment in the fiscal year 1950-51 was \$316.76, as compared to \$352.54 in 1949-50. The total number of individual patients treated was 3,082 in 1950-51, as compared to 2,481 in 1949-50, an increase of 601.

1,899 children treated 1948-49 at a per capita cost of \$351.99; 2,481 children treated 1949-50 at a per capita cost of \$352.54; 3,082 children treated 1950-51 at a per capita cost of \$316.76

State Headquarters for the Commission is 302 Heyburn Building, Louisville, Kentucky, with hospital and unit centers at Louisville, Ashland, Covington, and Lexington. Physical therapy centers are open daily at Covington, Lexington, and Louisville, with part-time centers at Ashland, Owensboro and Paducah.

In addition to the seven Commission members and the doctors serving on the medical staff, the regular staff of the Commission consists of:

- 1 Medical Director, part-time (beginning July 1, 1951)
- 1 Director, full-time
- 3 Medical-Social Consultants
- 4 Orthopedic Public Health Nurses
- 7 Physical Therapists
- 2 Occupational Therapists
- 1 Speech Therapist
- 1 Psychologist, full-time (beginning September 1, 1951)

- 1 Consulting Psychologist, part-time
- 1 Administrative Assistant
- 16 Secretarial and clerical workers

The Commission and staff wish to express appreciation for the splendid cooperation and assistance given by the State Health Commissioner, the County Health Officers and their staffs, the doctors on the professional staff of the Commission, and the other medical men of the state. While the Commission's report is ended each year with a similar statement, recognition of the fine services rendered by the medical profession of the state to crippled children is nevertheless most sincere. Your help is valued and is the Commission's assurance of a high-standard medical care program.

Respectfully submitted,  
COMMITTEE ON CRIPPLED  
CHILDREN

/s/ K. Armand Fischer  
K. Armand Fischer, Louisville,  
Chairman  
Charles C. Garr, Lexington  
Charles F. Wood, Louisville  
Hal E. Houston, Murray

SPEAKER HOUSTON: The Committee on General Practice, Dr. Charles G. Bryant of Louisville. Dr. Bryant's report is in; it is being referred to Reference Committee number 4.



# **REPORT OF COMMITTEE ON GENERAL PRACTICE TO THE 1951 SESSION OF HOUSE OF DELEGATES**

As was noted in the report of the House last year by a similar committee, there has been a continuing improvement in the status of the general practitioner in Kentucky, just as elsewhere in the country. Much of this progress has been the result of the efforts put forth by the Academy of General Practice, a group organized for the express purpose of raising the standards of general practice.

There has been a very definite increase in the number of interns entering general practice following their hospital service. In line with this is a wholesome tendency on the part of some of the hospitals to establish residencies in general practice.

One of the most pleasing improvements from the standpoint of the general men in urban areas has been the establishing of sections of general practice within the framework of the various hospital staffs. These same institutions are showing a more lenient and reasonable attitude toward the admission of general men to their staffs.

There has been a very gratifying increase in the interest of general men in the activities of the state and county medical organizations, many of them taking a very active part.

The University of Louisville and the Academy of General Practice have collaborated to provide ample opportunity for postgraduate refresher courses, arranged to fit the specific need of the general men. These courses are offered at various centers throughout Kentucky, including the University of Louisville Seminar at Louisville each June and the seminar held in conjunction with the State Medical Association Meeting now in progress. There can be no doubt but that these courses of study have greatly improved the standard of medical practice and thus been beneficial to the people of Kentucky.

Your committee wants to repeat the desires of the general practitioners for a strengthening of the bonds between the various fields of our profession to insure a better standard of medical practice and a united front in our fight against political control of the art of healing.

Respectfully submitted,  
COMMITTEE ON GENERAL PRACTICE

/s/ Charles G. Bryant  
Charles G. Bryant, Louisville,  
Chairman  
Travis Pugh, Bowling Green  
William M. Brown, Corbin  
John W. Somerville, Maysville

**SPEAKER HOUSTON:** The Committee on Industrial Medicine and Surgery, Dr. Rowntree.

**DR. ROWNTREE:** Mr. Speaker, the report is filed with the Secretary.

# **REPORT OF COMMITTEE ON INDUSTRIAL MEDICINE AND SURGERY TO THE 1951 SESSION OF HOUSE OF DELEGATES**

In the past year the first Louisville Area Industrial Health Conference was held. One hundred twenty persons met at the Pendennis Club in Louisville on February 2, 1951. The program was arranged around the theme "Healthy Employees are Better Employees" and brought to Louisville outstanding speakers in the field of Industrial Health. Their aim in assisting with the conference was to help management overcome the problem of absenteeism, promote the conservation of manpower and gain an awareness of the dollars and cents importance of a well planned medical program in industry.

Edward Holmblad, M. D., Managing Director of the Industrial Medical Association, visited Kentucky in August to help develop an educational program for mine physicians. The plan includes a section for mine physicians at the next meeting of the Industrial Medical Association in Cincinnati and regional meetings thereafter.

Ashland has used the literature on trauma of the American College of Surgeons as a basis for study programs in both the county medical society and at their hospital staff meetings.

During the past year the Committee on Industrial Medicine and Surgery had one meeting. The committee recommended that (1) there should be improvement in small plant general health programs, and that county medical societies should encourage the establishment of health programs in more small plants; (2) better sanitation be introduced into plants throughout the state, and that practicing physicians and the State Department of Health should aid in promoting this type improvement; (3) more hospitalization insurance be made available and that the coverage be extended to families as well as workers; and (4) it endorse the recommendation of the Kentucky Heart Association that physicians carefully evaluate heart cases and attempt to make proper placement for them on the job.

Respectfully submitted,  
COMMITTEE ON INDUSTRIAL MEDICINE AND SURGERY

/s/ Gracie R. Rowntree  
Gracie R. Rowntree, Louisville,  
Chairman  
R. W. Robertson, Paducah  
Clyde C. Sparks, Ashland  
Ira N. Kerns, Louisville

**SPEAKER HOUSTON:** The report is referred to Reference Committee number 4.

The report of the Committee on Mental Hygiene and Mental Institutions, Dr. Ackerly, Louisville.

**DR. ACKERLY:** Mr. Speaker, I wonder if I could just read one paragraph of the supplemental report. Your Committee on Mental Hygiene and Mental Institutions wishes to submit a supplementary report to the one already filed and in your folders. It is this, to wit: Your Committee recommends that the name of the Division of Hospitals and Mental Hygiene of the Department of Welfare be changed to that of Department of Hospitals and Mental Hygiene, which will function as a separate department of the state government.

#### **REPORT OF COMMITTEE ON MENTAL HYGIENE AND MENTAL INSTITUTIONS TO THE**

#### **1951 SESSION OF HOUSE OF DELEGATES**

While your committee, as a committee, met only once during the year, in March, 1951, individual members of the committee have been active in state hospital affairs, acting independently or serving on other committees. The chairman of this committee has been appointed by the Governor on executive order to be chairman of his Advisory Committee on State Hospitals.

We are pleased to note that progress has been made on several of the recommendations made in the 1950 report, namely, building and buying of suitable homes for physicians at the various hospitals, including a superintendent's home at the Training School, Frankfort. Besides the several houses that were bought, contracts have been let for several residences at both Eastern and Western State Hospitals. Contract is being let for two cottages for high grade patients at the Training School. Plans are being drawn up for a central tubercular unit at Central State Hospital and a member of our committee looked over the plans along with members of the Governor's committee.

The committee is also pleased to report that great strides are being made in developing a teaching hospital at Lakeland. Practically all of the Louisville psychiatrists have volunteered to teach at this hospital. It is hoped that next year this hospital will be approved as a training center for psychiatrists.

It is gratifying to note that a long-range functional program for the state hospitals is being worked out with emphasis on personnel and treatment facilities. The following includes some of these recommendations:

(1) The most pressing need is for increased personnel.

a. It is recommended that the salary limit

be raised since under the present Statutory limit it is impossible to employ an adequate number of experienced physicians.

b. Key people must be employed, especially in the categories of nursing, social work and psychology, with adequate salaries in order that these people may train others in their own divisions as well as train the attendant group.

c. Since there will be shortages of trained personnel for many years, we must concentrate on in-service training, especially of attendants. This can be aided by affiliation with University programs and the use of part-time professional people.

d. Personnel policies should be studied with a view of providing uniform benefits for all groups, but especially for the limited salary groups. Steps must be taken to provide for better quarters and more adequate recreation facilities.

e. It is recommended that an increase be made in the supervisory staff of the central office, which should include nursing service, social service and statistical personnel.

(2) It is recommended that studies be made and legislative changes be introduced to abolish criminal connotations in the commitment laws. Commitment to a state hospital should be on the basis of medical rather than legal considerations, providing the patient's rights are protected.

(3) Because of the lack of any type of psychiatric hospital facilities for children in Kentucky, it is recommended that a small children's psychiatric hospital be established with a full-time staff. This should be designed to accept disturbed children who require temporary hospital care.

(4) It is felt that out-patient departments of the state hospitals should be expanded, and that this might be accomplished in conjunction with the Mental Hygiene Division of the State Department of Health.

(5) Clinical research should be encouraged in our hospitals, but this again depends upon the recruitment of adequate personnel and not necessarily upon the expenditure of great amounts of money for equipment.

In contrast with the recommendations of other years, it is not felt that it is advisable to recommend the establishment of separate facilities for epileptics, since epileptics should be treated on an out-patient basis or else in existing mental hospitals should their mental condition require this.

Respectfully submitted,

**COMMITTEE ON MENTAL HY-  
GIENE AND MENTAL INSTI-  
TUTIONS**

Spafford Ackerly, Louisville,  
Chairman

COLL

OF KENTUCKY

CIANS



George H. Wilson, Lexington  
 Frank M. Gaines, Louisville  
 Billy K. Keller, Louisville  
 C. C. Howard, Glasgow  
 John P. Bell, Louisville

**SPEAKER HOUSTON:** His report and supplemental report are received and referred to Reference Committee number 4 for study. If there are any comments on the report or the supplemental report, please go to that committee.

The Committee on Obstetrics, Dr. Vogt of Louisville.

**DR. VOGT:** Mr. President, the report has been filed with the Secretary.

### **REPORT OF COMMITTEE ON OBSTETRICS TO THE 1951 SESSION OF HOUSE OF DELEGATES**

The Committee on Obstetrics had comparatively little work to do during the past year.

Two questionnaires were sent out from the American Medical Association by the Committee on Maternal and Child Care. Your state committee attempted to cooperate with them by answering to the best of its ability information that they needed in a survey precipitated by the present war picture. They are attempting to evaluate results of the E.M.I.C. Program (Emergency Maternal and Infant Care Program) that was in use during World War II.

Each of your committee, which are from different sections of the state, expressed himself. It was generally felt that the program had been inadequate. A second questionnaire was received asking if there was any need for a Maternal and Child Care Program for dependents of servicemen at this time. Your committee answered in the negative after contacting the Red Cross and other service organizations.

The reports from Oneida, Kentucky, are again favorable. This is where the state maintains a hospital and conducts a prenatal clinic. About eighty deliveries a month come under their care. It also serves as a consultant center for that district for any of the men practicing there that request it. Dr. Cathryn Handelman explained that the patient's financial status is screened. Of course patients are accepted when referred by private physicians. The medical personnel is from the Department of Ob. and Gyn. of the University of Louisville.

Dr. Handleman also had statistics on the maternal mortality of Kentucky from July, 1949, to July, 1950. She reported seventy-one maternal deaths in approximately seventy-six thousand deliveries. Continued careful checking of maternal and fetal mortality is indicated

as some counties still show a fairly large percentage of neo-natal deaths.

For the incoming committee it has been requested that the prenatal record forms used by state clinics be reviewed and that the Midwife Primer, now in use, also be checked.

Respectfully submitted,  
**COMMITTEE ON OBSTETRICS**  
 /s/ Rudy F. Vogt  
 Rudy F. Vogt, Louisville, Chairman  
 Coleman McDevitt, Murray  
 Stanley Parks, Lexington

**SPEAKER HOUSTON:** The report is in and is now being referred to Reference Committee number 4 for study.

The Committee on Pediatrics, Dr. Nicholson of Louisville. Dr. Nicholson's report is in and is being referred to Reference Committee number 4.

### **REPORT OF COMMITTEE ON PEDIATRICS TO THE 1951 SESSION OF HOUSE OF DELEGATES**

The present Pediatric Committee has had a limited existence. Despite this, the committee has had a meeting with the Director of the Division of Maternal and Child Health. At this meeting the main topic under discussion was the desire on the part of the State Department of Health to see more immunizations for the preventable diseases, chiefly through the practicing physician. At the same time the committee agreed that a report to the county health department from the physician would give a complete picture of immunizations over the state.

The members of the committee have reviewed and submitted their comments on:

(1) A suggested immunization schedule (for county health department personnel).

(2) The basic MCH Plan for Kentucky as submitted to the Children's Bureau for the fiscal year 1951-1952.

Members of the committee cooperated actively with the University of Louisville School of Medicine and the Academy of General Practice to make successful the post-graduate course in pediatrics given at the Children's Hospital in the spring of 1951.

Respectfully submitted,  
**COMMITTEE ON PEDIATRICS**  
 /s/ Wm. W. Nicholson  
 W. W. Nicholson, Louisville,  
 Chairman  
 Robert L. Biltz, Newport  
 Lon C. Hall, Paintsville

**SPEAKER HOUSTON:** The Committee on Physical Therapy, Dr. Owen B. Murphy of Lexington. The report is being referred to

Reference Committee number 4.

**REPORT OF COMMITTEE ON PHYSICAL  
THERAPY TO THE  
1951 SESSION OF HOUSE OF DELEGATES**

I have not been called upon for advice during the year and of course we have not had any meetings during the year, except the Kentucky Chapter met on September 26, 1950, at 4:30 at the Columbia Auditorium, following the State Medical Meeting last year. Those present were Dr. Wood and myself. The Physical Therapists present were Miss Draper, who is President of the local chapter, and Miss Schaper, who is Vice-President, Mrs. Carolyn Randolph, Secretary, Miss Mary McDonnell, Advisory, and Mrs. Sarah Edlin, Legislation Chairman, of the Kentucky Chapter of the American Physical Therapy Association. At this meeting a discussion was held concerning the shortage of Physical Therapists, and methods to keep physical therapy on a medical prescription basis. There was a point brought up concerning legislation pending in the State Legislature to propose a law which would concern licensing of qualified Physical Therapists, and these were to be trained in schools approved by the American Medical Association Congress of Physical Medicine. It was also discussed that if these trained Physical Therapists were not made available that patients would probably seek other outlets in order to obtain some form of rehabilitation.

It is my understanding that during the past year that this legislation has been proposed under the heading Physical Therapy Act, and therefore is to be itemized in the following manner: Section I to include the definition of Physical Therapy, Section II concerning the practice of licensed Physical Therapists, Section III concerning those persons who are authorized to practice Physical Therapy, Section IV will bring out condition of the licenser. In other words, this was to cover completely the enactment and execution of all necessary qualifications to practice the specialty of Physical Therapy in Kentucky.

Other than the above, I do not believe that any other business has come before the Physical Therapy Committee, of which I have been chosen Chairman.

Respectfully submitted,  
**COMMITTEE ON PHYSICAL  
THERAPY**

/s/ O. B. Murphy

O. B. Murphy, Lexington, Chairman

Richard Hudson, Louisville

Robert Hahs, Murray

Gordon Buttorff, Louisville

McDaniel Ewing, Louisville  
W. K. Massie, Lexington

**SPEAKER HOUSTON:** The Committee on Rural Health, Dr. Walter L. O'Nan, Henderson.

**DR. O'NAN:** Mr. Speaker, this report is in your file.

**REPORT OF COMMITTEE ON RURAL  
HEALTH TO THE  
1951 SESSION OF HOUSE OF DELEGATES**

During January, 1951, the chairman met with Aubrey D. Gates, who was the representative of the American Medical Association in the rural health program on leave from the University of Arkansas Extension Service. His suggestions have been very timely and worth while.

In February, the chairman attended the Rural Health Conference at Memphis, Tennessee, and derived a great number of ideas for the program in our state. This was the sixth yearly conference of this nature.

In March, a preliminary meeting with representatives of a number of the various organizations throughout the state who are interested in the rural health program was held in Louisville, and the big outcome was to have a meeting of these and other interested people toward the formation of a Rural Health Council.

This meeting was held in May and the outcome was the formation of a Rural Health Council and the appointment of a Steering Committee to map out a program for that. This committee consisted of the following:

Sam A. Overstreet, M. D., President, Kentucky State Medical Association; Bruce Underwood, M. D., Commissioner, State Department of Health; A. B. Coxwell, D. M. D., Executive Secretary, Kentucky State Dental Association; J. E. Stanford, Executive Secretary, Kentucky Farm Bureau Federation; Miss Myrtle Weldon, State Leader, Home Demonstration Agents; Miss Margaret East, Director, Division of Public Health Nursing; and Miss Marjorie M. Wilson, Department of Economic Security.

This committee, due to illnesses and vacations has not had occasion to meet, but plans are made for the early fall meeting with added impetus toward the progress of this organization.

It is the suggestion of the chairman that this committee be enlarged with possibly a member from each of the councilor districts of the state; also, let each county have an organization of a similar nature, and in counties where there is an active cancer society, tuberculosis society, etc., attempt to graft the rural health



program with these organizations. We feel that use of existing personnel would greatly simplify the matter.

Respectfully submitted,  
**COMMITTEE ON RURAL HEALTH**  
 /s/ Walter L. O'Nan  
 Walter L. O'Nan, Henderson,  
 Chairman  
 Harry K. Dillard, Warsaw  
 Charles B. Johnson, Russell

**SPEAKER HOUSTON:** The report is received and is now being referred to Reference Committee number 4.

The Committee on Syphilis Control, Dr. Oscar E. Bloch of Louisville. Dr. Bloch's report is in, being referred to Reference Committee number 4.

#### **REPORT OF COMMITTEE ON SYPHILIS CONTROL TO THE 1951 SESSION OF HOUSE OF DELEGATES**

As usual, during the past year this committee has not been called upon for action of any sort and has therefore not had a meeting. Nevertheless its members feel that they have something worth saying about syphilis control in Kentucky as compared with the nation as a whole.

The only way to gauge whether control measures against syphilis are succeeding is by comparing the discovery rates of early syphilis for successive periods of time. It has now been ten years since reporting by stages began in the United States. An editorial in the Journal of Venereal Disease Information in July, 1949, records that the civilian case rate then reported for the United States was about 50% of the peak rate reported in early 1947. The Army and Navy had shown similar decreases.

Has the same thing happened in Kentucky? Figures provided by the State Department of Health show that the reported cases of early syphilis in 1950 were even less than 50% of the peak 1947 figures. Surveying the discovery rate since 1941, the trend has been downward, though with some irregularities.

In some years, the cases of early latent syphilis have outnumbered those of primary and secondary syphilis, occasionally by as much as 2 to 1, which implies that a good many early active cases are not discovered before latency begins and their most infectious phase has passed.

It is also important that the percentage of all cases reported by private physicians has doubled since 1941. In Louisville, where even more striking reduction of reported cases has occurred since 1947, the percentage reported

by physicians has gone from 0.7% in 1945 to 49% in 1947 and 44% in 1950.

In short, it looks as if control measures are showing results and as if more of the control effort is devolving upon the private physicians instead of the public clinic. This latter change is, of course, due to the simplicity of treating syphilis with penicillin.

Before concluding that the above statistics indicate a true reduction in the incidence of syphilis, it is necessary to consider a number of technical factors listed in the above-mentioned editorial and which will not be discussed in this report. An analysis of these factors leads to the conclusion that there is a decreased incidence of syphilis in those communities of nation and state which have case-finding and reporting systems. But it appears from case-finding projects in unorganized communities that there has not been a parallel reduction of syphilis incidence in them.

In consideration of the partial success of syphilis control efforts in most areas it is obvious that similar efforts must be applied everywhere in the state and country, and since private physicians are seeing a larger proportion of all the early syphilis than hitherto, they must, even more than before, consider themselves responsible for contact investigation, in cooperation with health departments.

Respectfully submitted,  
**COMMITTEE ON SYPHILIS CONTROL**  
 /s/ Oscar E. Bloch, Jr.  
 Oscar E. Bloch, Jr., Louisville,  
 Chairman  
 C. C. Barrett, Lexington  
 William Lamb, Louisville

**SPEAKER HOUSTON:** The Committee on Tuberculosis, Dr. E. R. Gernert, Louisville.

**DR. GERNERT:** Mr. Speaker, the report has been filed.

#### **REPORT OF COMMITTEE ON TUBERCULOSIS TO THE 1951 SESSION OF HOUSE OF DELEGATES**

The following recommendations are submitted:

1. **HOSPITAL ADMISSIONS.** At present the directors of the state sanatoria have full and final responsibility for passing on all applications for admission. We recommend that rejections, on request of the patient or his physician, be reviewed by two members of the Sanatorium Commission, one of whom shall be a physician. Decision of the two Commission members shall be final.

2. **PHOTOFLUOROGRAPHIC CHEST X-RAY SURVEYS.** Mobile units of the State Department of Health have not been able to get into

all counties due to a small minority of objectors. We recommend that the Kentucky State Medical Association endorse this case-finding program on a state-wide basis, with no counties excepted.

3. FOLLOW-UP X-RAYS. Screening surveys lose value in direct proportion to the number of persons who should have a large film follow-up but fail to get it. In accordance with the policy already adopted by many states, municipalities, and the U. S. Public Health Service, we recommend that in all chest X-ray surveys the large film follow-up where indicated be made an integral part of the case-finding program without expense to the patient.

4. ISOLATION. With respect to uncooperative tuberculosis patients, local boards of health now have the power of quarantine in such cases (Kentucky's Administrative Code, 1946). It is rarely used in tuberculosis, and if used would offer no protection to other susceptible persons in the same household. The committee is in accord with the principle that legislation to provide restraint and isolation of such individuals in hospitals is proper. It is our conclusion that with the absence of any locked wards and the present limited number of hospital beds, administration of such a measure would be difficult. For the above reasons no recommendation for a law to provide forcible isolation is made at this time.

Respectfully submitted,

COMMITTEE ON TUBERCULOSIS  
/s/ E. R. Gernert

E. R. Gernert, Louisville, Chairman

E. J. Murray, Lexington

L. O. Toomey, Bowling Green

T. Ashby Woodson, Louisville

P. M. Crawford, Louisville

#### **SUPPLEMENTARY REPORT OF COMMITTEE ON TUBERCULOSIS TO THE**

#### **1951 SESSION OF HOUSE OF DELEGATES**

The following recommendations of the Committee on Tuberculosis are transmitted for the information and consideration of the Council.

The Committee met at 4:30 P. M., on August 31, 1951, at 316 Francis Building, Louisville, Kentucky.

Present: E. R. Gernert, M. D., T. A. Woodson, M. D., P. M. Crawford, M. D.

Absent: E. J. Murray, M. D., L. O. Toomey, M. D.

The first matter taken up was action of the State Department of Health in requiring all chest X-rays taken by local Health Departments, to be sent in to the State Health De-

partment without delay for interpretation and report by a phthisiologist and a cardiologist. The basis for such action as given by the State Health Department is that this procedure makes for prompt and standardized reporting on films which it has furnished. The films are always returned to the local Health Department where they are available for recheck by local physicians. Your Committee concurs in the action taken by the State Department of Health.

The Chairman, Dr. Gernert, next gave the Committee information regarding the State Tuberculosis Hospital situation. A letter was read from Dr. Oscar O. Miller, member of the State Tuberculosis Hospital Commission. Dr. Miller informs us that the Ashland, Paris, London, and Glasgow Tuberculosis Hospitals are all filled; Madisonville Hospital is seventy per cent occupied; the Louisville Hospital at Hazelwood has recently had an average of forty to fifty vacancies, credited largely to transfer of patients back to their home districts as the new hospitals opened. Your committee takes this occasion to congratulate the State Tuberculosis Hospital Commission on the progress which has been made with the Hospital Program.

Your Committee notes a rather disturbing tendency on the part of many physicians to make less use of sputum studies in the diagnosis of pulmonary tuberculosis than is desirable. The same remark is applicable to the follow-up studies of many known cases. In view of the definite limitation of the X-ray in the diagnosis of intra-thoracic conditions, and in the management of pulmonary tuberculosis your Committee feels strongly that the tendency above mentioned is to be deplored. Attention is invited to the fact that complete sputum studies including culture and animal inoculation when indicated are available at the State Health Department Laboratory. Mailing containers are obtainable at all local Health Departments.

The Chairman, Dr. Gernert, informed the Committee that he had received a letter relative to the non-admission to Hazelwood Hospital of a Shepherdsville resident as a free patient. The Committee concurs in Dr. Gernert's action of referring the letter to Mr. J. D. Miller, Executive Director of the Kentucky State Hospital Commission.

The question of routine chest X-rays on all persons admitted to hospitals was considered and discussed. There was general agreement among Committee members that this group of individuals is a fertile source of pulmonary tuberculosis and other intra-thoracic disease. Undiagnosed active pulmonary tuberculosis is a grave health hazard to either hospital pa-



tients or hospital employees. It is recommended that all hospitals having X-ray equipment adopt a policy of routine chest X-rays on all admissions.

Dr. Crawford informed the Committee that information received from Mr. J. D. Miller, Executive Director of the Hospital Commission, indicates that the Appeal Board previously recommended by the Committee for considering rejected applicants for the State Tuberculosis Hospitals has been set up. Mr. Miller stated that the Appeal Board is composed of all the Medical Directors of the State Tuberculosis Hospitals. The Committee feels that while this is a step in the right direction it does not entirely meet the requirements of the situation. Your Committee recommends that such an Appeal Board contain at least two physicians from outside the State Hospital, and that one of these physicians be a member of the State Tuberculosis Hospital Commission.

Respectfully submitted,

**COMMITTEE ON TUBERCULOSIS**

/s/ E. R. Gernert

E. R. Gernert, Louisville, Chairman

E. J. Murray, Lexington

L. O. Toomey, Bowling Green

T. Ashby Woodson, Louisville

Col. P. M. Crawford, Louisville

**SPEAKER HOUSTON:** The report is in and it is now being referred to Reference Committee number 4.

Now we are ready for the report of the other advisory committees. The Advisory Committee of the Woman's Auxiliary, Dr. W. Clark Bailey, Harlan.

**DR. BAILEY:** Mr. Speaker, the report has been filed.

**REPORT OF ADVISORY COMMITTEE  
TO WOMAN'S AUXILIARY  
TO THE  
1951 SESSION OF HOUSE OF DELEGATES**

The Woman's Auxiliary is organized only to assist in the work of the Kentucky State Medical Association and under its direction. Its organizational structure is somewhat similar to that of the Kentucky State Medical Association and its committees must, of necessity, outline their programs. The auxiliary has 816 active members and has added two new component societies during the past year.

Among its many achievements have been the sponsoring of a College Editors' Contest in Senior Colleges in Kentucky on Americanism; the presentation of one year's subscription to "Today's Health" to the editorial staff of each

college newspaper in Kentucky and to each Congressman and United States Senator from Kentucky; the sponsoring of a Radio Quiz program for school children of the elementary grades; the sponsoring of a Tuberculosis Essay Contest in Kentucky among the junior high school students; the sponsoring of a public speaking contest on "Cancer" among the senior high school students of Kentucky, and splendid progress toward the furnishing of Ephraim McDowell House at Danville.

The Auxiliary has been most cooperative with the committees of the Kentucky State Medical Association, and has accomplished much in the field of public relations. Its members are busy as members of P.T.A., Woman's Clubs, and other organizations in representing our profession in the actual application of the American way of life. We are most grateful for their loyalty. It is our hope that every doctor will encourage his wife to be a member and active worker in the Woman's Auxiliary.

Respectfully submitted,

**REPORT OF ADVISORY COMMITTEE TO WOMAN'S AUXILIARY**

/s/ W. Clark Bailey

W. Clark Bailey, Harlan, Chairman

J. B. Lukins, Louisville

Bruce Underwood, Louisville

**SPEAKER HOUSTON:** The report is in. It is being referred to Reference Committee number 4.

Advisory Committee for the United Mine Workers Health and Welfare Fund, Dr. C. D. Snyder, Hazard. The report is in, it is being referred to Reference Committee number 4.

**REPORT OF COMMITTEE ON UNITED MINE  
WORKERS HEALTH AND WELFARE FUND  
TO THE  
1951 SESSION OF HOUSE OF DELEGATES**

The committee on United Mine Workers Health and Welfare Fund has had no meetings since nothing has been referred to it so far this year. We have, therefore, nothing to report.

Respectfully submitted,

**COMMITTEE ON UNITED MINE  
WORKERS HEALTH AND  
WELFARE FUND**

/s/ C. D. Snyder

C. D. Snyder, Hazard, Chairman

Robert S. Howard, Harlan

Carl Fortune, Lexington

Adam Osborne, Pikeville

Charles Yancy, Hopkinsville

George F. Brockman, Greenville

The reports of the other Convention Committees, the Committee on Technical Exhibits, Dr. Carlisle R. Petty of Louisville. The report is in, is being referred to Reference Committee number 2 for study.

#### **REPORT OF COMMITTEE ON TECHNICAL EXHIBITS TO THE 1951 SESSION OF HOUSE OF DELEGATES**

Sixty-four spaces have been sold in the technical exhibit hall for our Centennial Meeting. The rental from the sale of these will amount to \$8,925, as compared to the all-time high of last year's record of \$7,500 collected from 55 spaces

The largest part of the credit for the success of our Committee goes to our Executive Assistant, Mr. J. P. Sanford. He has had all but a few of the spaces sold for months, and could have sold more.

All of our technical exhibitors are displaying products approved by the American Medical Association.

It is with pride that we report progress in the type of meeting our exhibitors are helping to create.

Respectfully submitted,

**COMMITTEE ON TECHNICAL EXHIBITS**

/s/ Carlisle R. Petty

Carlisle R. Petty, Louisville, Chairman

J. Spalding Abell, Jr., Louisville

Clyde H. Foshee, Louisville

E. L. Shiflett, Louisville

Arthur T. Hurst, Louisville

**SPEAKER HOUSTON:** The Committee on Scientific Exhibits, Dr. E. L. Pirkey, Louisville. It is in and is being referred to Reference Committee number 2 for study.

#### **REPORT OF COMMITTEE ON SCIENTIFIC EXHIBITS TO THE 1951 SESSION OF HOUSE OF DELEGATES**

Two formal meetings have been held, the first on March 23, 1951, at the Columbia Auditorium in Louisville, with all members of the committee present. Sam A. Overstreet, M. D., President, Mr. Joe Sanford, Executive Assistant, and representatives of the Jos. T. Griffin Company also attended. At the meeting a survey was made of the facilities available for the scientific exhibit of the Centennial Meeting. It was the feeling of the committee that the balcony area of the gymnasium would be adequate, with the expenditure of some money. Preliminary plans were drawn at the meeting.

Following this meeting, notices for the ex-

hibit were inserted in the State Medical Journal, and each scheduled speaker was contacted.

A meeting was held on August 1, 1951, at St. Joseph Infirmary. All members of the committee were present except Harold Gordon, M. D., who was out of the city. Mr. Joe Sanford and representatives of the Jos. T. Griffin Company also attended. At this time twenty-five exhibits were selected from the applications received and the spaces allocated.

Thanks to the exceptional cooperation this committee has received from our President, the Secretary and the Governing Board of this Association, the scientific exhibit at this meeting will be, by far, the largest and most informative that has ever been presented.

Respectfully submitted,

**COMMITTEE ON SCIENTIFIC EXHIBITS**

/s/ Everett L. Pirkey

Everett L. Pirkey, Louisville, Chairman

D. Woolfolk Barrow, Lexington

Harold Gordon, Louisville

Charles F. Wood, Louisville

Jesshill Love, Louisville

**SPEAKER HOUSTON:** The special reports, the report on Rural Kentucky Medical Scholarship Fund, Dr. C. C. Howard of Glasgow.

**DR. HOWARD:** The report has been filed.

#### **REPORT OF BOARD OF TRUSTEES OF THE RURAL KENTUCKY MEDICAL SCHOLARSHIP FUND TO THE 1951 SESSION OF HOUSE OF DELEGATES**

I am pleased to report to you the Rural Kentucky Medical Scholarship Fund's progress. We have loaned to forty-three boys who are now studying medicine. We have loaned to twelve who are now practicing medicine. We have loaned to seven who are now interning. We have loaned \$99,350.00. We are working out a program whereby we contact these boys and their wives and make a study of their outlook on rural practice.

Mr. Dixon, our secretary, has done a most admirable job in contacting all applicants and those to whom we have made loans; also drawing maps of the state showing the areas in greatest need and those that are not so desperate. The following men have located at:

O. C. Cooper, M. D., Wickliffe, Ballard County

Carson E. Crabtree, M. D., Buffalo, Larue County

Oscar A. Cull, M. D., Corinth, Grant County

William G. Edds, M. D., Kenvir, Harlan County, temporarily



Jack B. Mershon, M. D., Delphia, Perry County

Edward W. Miller, Jr., M. D., Leitchfield, Grayson County

Clyde J. Nichols, M. D., Clarkson, Grayson County

Alfred P. Peretti, M. D., Corbin, Whitley County

John M. Smith, Jr., M. D., Beattyville, Lee County

Benjamin C. Stigall, M. D., Livermore, McLean County

William L. Taylor, M. D., Guthrie, Todd County

Loman C. Trover, M. D., Earlington, Hopkins County

This committee, as you well know, is composed of doctors and laymen. We have an annual dinner to meet the boys and wives we are sponsoring. This is always a helpful and enjoyable occasion. We would be glad for any doctor to attend.

Respectfully submitted,

BOARD OF TRUSTEES OF THE  
RURAL KENTUCKY MEDICAL  
SCHOLARSHIP FUND

/s/ C. C. Howard

C. C. Howard, M. D., Glasgow,  
Chairman

John Walker Moore, M. D.,  
Louisville

Carl Norfleet, M. D., Somerset

Charles Stacy, M. D., Pineville

Mr. Clarence Miller, Shelbyville

Mr. Tarleton Collier, Louisville

J. Murray Kinsman, M. D.,  
Louisville

Sen. Cass Walden, Edmonton

Mr. H. F. Wilkie, Louisville

R. Haynes Barr, M. D., Owensboro

Bruce Underwood, M. D.,  
Louisville

G. L. Simpson, M. D., Greenville

Hugh L. Houston, M. D., Murray

Mrs. John E. Kirksey, Paducah

Mr. Paul W. Grubbs, St. Matthews

Mrs. Charles Shelton, Louisville

**SPEAKER HOUSTON:** It is being referred to Reference Committee number 3 for study.

The report of the Medical Research Commission, Dr. C. C. Howard of Glasgow.

**DR. HOWARD:** The report has been filed.

#### **REPORT OF THE MEDICAL RESEARCH COMMISSION TO THE 1951 SESSION OF HOUSE OF DELEGATES**

The Medical Research Commission was set up by a law sponsored by the medical profession to aid the Medical Department of the

University of Louisville. This commission has been operating since 1948. We invite all the profession to visit the Medical Research Department at the General Hospital in Louisville which these funds made possible for medical education. There has been marked improvement in this phase of medical teaching since the commission was able to assist them. The number of rural students from Kentucky who have been admitted has been increased on the average of twenty each year. This has been very helpful. We feel that this has been a good solution for the medical teaching problem of the medical schools and the state. We are going to request that this fund be increased in the next legislature. There is fine cooperation between the commission and the dean and faculty of the school.

Respectfully submitted,

MEDICAL RESEARCH COMMISSION

/s/ C. C. Howard

C. C. Howard, Glasgow, Chairman

Guy Aud, Louisville

B. B. Baughman, Frankfort

J. Murray Kinsman, Louisville

Mr. E. H. Hackney, London

**SPEAKER HOUSTON:** We have the report of the Woman's Auxiliary, Mrs. Clark Bailey of Harlan. Mrs. Bailey's report is in and is being referred to Reference Committee number 3 for study.

#### **REPORT OF THE PRESIDENT OF THE WOMAN'S AUXILIARY TO THE KENTUCKY STATE MEDICAL ASSOCIATION TO THE 1951 SESSION OF HOUSE OF DELEGATES**

It has been a great pleasure, as well as a privilege, to serve as President of the Woman's Auxiliary to the Kentucky State Medical Association. The months have been very busy ones and much too short to carry out all of its objectives. We have tried to plan our program to strengthen the Auxiliary, not only for this year but for the years which lie ahead. As President, it has been my desire to be of help to the County Auxiliaries and to serve them when called upon.

Organization has progressed mainly in extension of members-at-large to counties formerly completely unorganized. Fifty-two members-at-large in 34 counties, plus 25 auxiliaries (two new) in 41 counties, gives Kentucky 74 counties organized out of 120, as compared with 60 organized in September, 1950. Three county organizations are in preliminary stages (Henderson, Pike, Clark), and one Auxiliary including four counties divided into two Auxiliaries, with one adding a county, which organized one more county and increases the

Auxiliaries by one. Membership has increased more than 50, and five district meetings were held.

Number of County Medical Societies in the state .....	117
Number of members in State Medical Association .....	1767
Number of new County Auxiliaries organized the past year .....	2
Number of organized County Auxiliaries	25
Number of members-at-large this year...	52
Total number of members.....	816

Among some of our activities, we obtained four hundred copies of "Medicine and the Welfare State" from the Council on Merit Medical Service of the American Medical Association to be used in connection with the high school debate, the subject for debate in 1951 being, "Resolved that the American People Reject the Welfare State." We found that not all of the high schools planned to enter the debate, but the material prepared was so excellent that we have tried to place it in the libraries to be used when and where needed. Along with "Medicine and the Welfare State," we sent booklets entitled, "This is Our Problem," donated by Swift and Company, with the hope that it would stimulate the thinking and appreciation of loyalty to our country and its traditions.

It came to our knowledge that all of the college and university editors in this country were receiving from various sources much Socialistic propaganda to be used either in the student publications or as material for programs on the campus. In order to offset this propaganda in our own state, our Auxiliary sponsored a College Editors Contest in senior colleges in Kentucky on Americanism. Every editorial staff of every senior college was visited personally to explain the purpose of the contest. We were generally well received. The contest ran from November 11th to February 22nd. We feel that in this contest seeds of inspiration were sown in the minds of many college students who might have otherwise been indifferent. It was suggested by one college editor that the International Relations Clubs on the campuses of the colleges and universities be contacted by our national organization through some similar plan. It was stated by this editor that we would be amazed at the literature received by the International Relations Clubs. The prizes for the winners of this contest were fifty dollars in American History books for first place, and twenty-five dollars in American History books for second place.

One of the primary interests of the Auxiliary is health education. To have a great country we must have strong, healthy, loyal people.

Knowledge of our country and the basic principles upon which it is built, knowledge of our health and the basic principles of staying healthy are necessary to our people.

A healthy, well-equipped army can quickly crush its foe. A sick army, no matter how well-equipped, is soon defeated. A radio quiz program is being put on by the Auxiliary in Kentucky where the children in the elementary grades appear on the radio and answer questions about their health and their country. The children love to be on the radio; the other school children listen in; the mammas, the poppas, the aunts and cousins all want to hear Johnny broadcast.

In Kentucky we have an essay contest on tuberculosis sponsored by the Auxiliary, in which we give fifty dollars to the junior high school student who writes the best essay. The student must not only study but must learn and know the facts about tuberculosis before he can write a prize-winning essay.

The Cancer Committee of the Auxiliary sponsored a public speaking contest open to students of Kentucky high schools, 9th through 12th grades. The subject of the contest was "Cancer." The contest was held in cooperation with the American Cancer Society (Kentucky Division) and the University of Kentucky Extension Department. The statewide contest occurred April 30 at Memorial Hall on the University of Kentucky campus in Lexington. The aims of this contest were two-fold. First, to acquaint a very responsive and fundamental group—the senior high school group—with the dangers of cancer and its control through early diagnosis. Second, by so introducing the subject "cancer," we are helping to promote health education and thus make a healthier group who will serve in the future of our state.

In the field of public relations, our slogan for this year has been "Public Relations is You." Auxiliary members have taken an active part in local drives for the Heart Association, TB, March of Dimes, Crippled Children, Red Cross and local Community Chests. All counties reported participation in local health projects, and members have assumed leadership in organizations which have health as an objective. Cooperation with the local health department with programs and speakers was reported. Getting out the vote and having doctors' families registered to vote was stressed this year. Auxiliary members were asked to assist in their communities in setting up civilian defense. PTA and AAUW continued to be targets—articles were written for the "Blue Grass" News. A quiz was made up for the PR Conference at the Convention and correspondence carried on with various county PR chairmen by the state chairman.



Resolutions from Kentucky number 245, plus 18 from state organizations.

The American Medical Association has asked every state Auxiliary to sponsor the sale of "Today's Health." It is our desire to see every physician in the state of Kentucky a subscriber and to cooperate with the Auxiliary in recommending it to his patients who desire authentic health information, "Today's Health" being the only authentic health magazine published.

In the "Today's Health" contest sponsored by the A.M.A., we are very glad that the Muhlenberg County Auxiliary was the winner in the national contest, receiving an award of fifteen dollars. The Daviess County Auxiliary gave a subscription of "Today's Health" to each Senator and Representative from Kentucky. With each of the subscriptions, we also gave a one-year subscription to "Sunshine" magazine. A personal letter was written to each recipient of gift subscriptions expressing the desire of our organization to cooperate with them in maintaining and protecting our great American way of life.

Since one of the Auxiliary objects is to participate in any endeavor on the request of the Medical Association, we are more than happy to have a part in the Historical Exhibit for the Centennial Meeting. We consider it a privilege to have the opportunity to serve the medical profession.

During the year we have made much progress in the completion of the Ephraim McDowell shrine. With the addition of draperies and many pieces of furniture, the house begins to take on a finished look. We invite you to stop at the shrine in Danville, Kentucky, any time you are in this area.

Respectfully submitted,

WOMAN'S AUXILIARY TO THE  
KENTUCKY STATE MEDICAL  
ASSOCIATION

/s/ AGNES BAILEY

Mrs. Clark Bailey, Harlan

President

**SPEAKER HOUSTON:** The report of the Board of Directors of the Kentucky Physicians Mutual, Inc., Frankfort.

**DR. BAUGHMAN:** Mr. Speaker, Delegates. The report of the Board of Directors of the Kentucky Physicians Mutual has been made. You have a copy of it, and I have nothing to add to this. In accordance with the constitution and the by-laws of the Kentucky Physicians Mutual each year the House of Delegates must submit a list of eleven names to the Board of Directors from which seven doctors are elected to serve a term of three years each. At this time I would like for you to hear from

the delegate from Kenton County, Dr. Pierce.

**DR. PIERCE:** The Committee wishes to suggest these names for the House of Delegates as the eleven from which seven are to be chosen as members of the Board of Directors, each man to serve for three years to replace the seven who are outgoing this year. The following names are submitted: Dr. Richard J. Rust of Newport, who is a surgeon; Dr. John T. Walsh of LaGrange, who is, I believe, a general practitioner; Dr. J. Duffy Hancock of Louisville, who is a surgeon; Dr. Kenton D. Leatherman of Louisville, who is an orthopedic surgeon; Dr. Coleman C. Johnston of Lexington, who is a general surgeon; Dr. R. W. Robertson of Paducah, who is a general surgeon; Dr. Max D. Klein of Shelbyville, who is a general practitioner; Dr. John Dickinson of Glasgow, who is a general surgeon; Dr. Matthew Darnell of Lexington, who is a general practitioner; Dr. Joseph Bell of Louisville, who is a roentgenologist; Dr. Tom Meredith of Harrodsburg, who is a general practitioner.

#### **REPORT OF BOARD OF DIRECTORS OF KY. PHYSICIANS MUTUAL, INC., TO THE 1951 SESSION OF HOUSE OF DELEGATES**

The president of the Kentucky Physicians Mutual, Inc., has the honor to report for the Board of Directors that the Corporation has had an excellent year. We have enjoyed remarkable progress for the second year of our existence.

We have been interested in four forward steps in the past year. Three of these have been achieved.

(1) We have repaid in full, with interest, the \$25,000.00 which was loaned us by the Kentucky State Medical Association.

(2) We have made available to the public an individual contract, in addition to the original group contract with which we started.

This means that any individual in Kentucky 65 years of age or under may purchase our contract for himself and for his family.

(3) We have just completed a full revision of the schedule of indemnities with an increase in the amount paid for the majority of surgical procedures, in addition to a broadening of the medical fee scale.

The above three items have been of great personal concern to us. In revising the fee schedule we have sought and obtained the advice of the entire board of directors, in addition to recognized specialists in various specialized fields of surgery in which the schedule was totally inadequate, in addition to professors of the leading specialties in the University of Louisville School of Medicine. We now have a schedule with higher fees than any

of the commercial insurance companies and higher than the majority of other state Blue Shield companies. We have done this in part with the hope that in the near future the physicians of Kentucky will accept a service contract for people of low income.

(4) We have had the goal of every county of Kentucky being signed up by over 51% of the physicians as participating in the plan. In August, 1950, we had 44 counties signed up. We are very gratified that we now have 104 counties signed up, as of September 17, 1951. It is our hope that very soon we will have all of the 119 counties in Kentucky signed as participating (Boyd County, the 120th, has another Blue Shield plan and is not to be solicited), thereby giving positive evidence that Kentucky doctors are solidly behind our plan. We have held, and will continue to hold, to the belief that the plan should not be sold in a county unless at least more than half of the doctors in that county sign up as participating physicians.

#### **Sales Promotion:**

On August 31, 1950, there were 43,386 individuals covered by the plan.

On August 31, 1951, there were 87,144 individuals covered.

The Blue Cross organization has put on well organized drives to sell Blue Cross-Blue Shield contracts in various parts of the state. These have been on the highest plane of dignity and ethics and have made good use of radio and newspaper advertising. Hospitals and physicians have strongly backed the drives in every instance. This will continue in all parts of the state. The only counties not signed as participating and in which contracts cannot be sold are the following: (As of September 17, 1951) Breathitt, Carter, Floyd, Hancock, Hart, Jessamine, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Pike, Simpson and Wolfe. We are extremely grateful for the active and efficient backing given us by the Medical Economics Committee of the Kentucky State Medical Association.

#### **Financial Condition:**

The complete financial standing of the corporation will be found in the attached statement as of August 31, 1951. Attention is called to the fact that a year ago our assets totaled \$141,184.00, whereas on August 31, 1951, they totaled \$393,470.21, \$100,000 of which we have invested in government bonds. Our surplus as of August 31, 1950, was \$74,000.00, whereas on August 31, 1951, it was \$185,841.68.

#### **Summary and Recommendations:**

Kentucky Physicians Mutual, Inc., is proud of its record of the past two years. Its accomplishments have been listed above. The

criticisms it has received from physicians have been duly noted and, if possible, the indicated adjustments have been made. We continue to solicit your ideas for improvement since this is your plan. We have and shall continue to give our time unselfishly and without compensation to the corporation.

We urge that you attempt to accept the fees paid as the greater part, or all of the fee charged, instead of raising your fees higher when you learn that the patient has insurance and thereby attempting to "kill the goose that laid the golden egg."

We sincerely seek the positive and aggressive support of the medical profession of Kentucky, and we urge that you keep our literature in your office and urge our plan on your patients, for in this way you can strike a blow at the root of the evil of socialism in medicine.

We ask that you give serious and careful thought to the establishment of a service contract for low income groups in the near future. The need is great and such a contract is available in over 40 states.

Since the term of the usual one-third of the directors (nine in number) expires this year, we request that in accordance with the Articles of Incorporation the House of Delegates submit eleven names for consideration by the Kentucky Physicians Mutual, Inc., in the selection of seven physicians to fill the vacancies of the following: Clark Bailey, Harlan; W. H. Barnard, Elizabethtown; R. Haynes Barr, Owensboro; F. L. Duncan, Monticello; E. S. Dunham, Edmonton; T. O. Meredith, Harrodsburg; R. J. Rust, Newport.

We wish to express our deep appreciation to Oscar O. Miller, M. D., the father of Kentucky Physicians Mutual, Inc., and its guiding light, for his sound judgment and untiring efforts in behalf of the corporation.

Respectfully submitted,  
KENTUCKY PHYSICIANS  
MUTUAL, INCORPORATED  
/s/ B. B. BAUGHMAN

Branham B. Baughman, M. D.,  
Frankfort, President

#### **OFFICERS**

President, B. B. Baughman, M. D., Frankfort  
Vice-President, W. Vinson Pierce, M. D., Covington  
Secretary-Treasurer, Bruce Underwood, M. D., Louisville  
Asst. Secretary-Treasurer, Mr. Raymond F. Dixon, Louisville  
Executive Director, Mr. D. Lane Tynes, Louisville  
Medical Consultant, William A. Blodgett, M. D., Louisville



## BOARD OF DIRECTORS

Name	Term Expires	
Clark Bailey, M. D., Harlan.....	1951	Mr. R. A. Dean, Sr., Louisville.....1952
W. H. Barnard, M. D., Elizabethtown....	1951	J. B. Lukins, M. D., Louisville.....1952
R. Haynes Barr, M. D., Owensboro.....	1951	W. Vinson Pierce, M. D., Covington....1952
F. L. Duncan, M. D., Monticello.....	1951	J. G. Samuels, M. D., Hickman.....1952
E. S. Dunham, M. D., Edmonton.....	1951	Charles B. Stacy, M. D., Pineville.....1952
T. O. Meredith, M. D., Harrodsburg....	1951	Bruce Underwood, M. D., Louisville....1952
Mr. S. A. Ruskjer, Louisville.....	1951	Ralph W. Allen, M. D., Pikeville.....1953
Richard J. Rust, M. D., Newport.....	1951	William H. Cartmell, M. D., Maysville...1953
Mr. J. E. Stanford, Louisville.....	1951	Mr. H. J. Fenton, Murray.....1953
B. B. Baughman, M. D., Frankfort....	1952	Oscar O. Miller, M. D., Louisville.....1953
A. L. Cooper, M. D., Somerset.....	1952	Mr. W. Emmet Milward, Lexington....1953
		Walter L. O'Nan, M. D., Henderson....1953
		J. Vernon Pace, M. D., Paducah.....1953
		Samuel E. Paris, M. D., Bowling Green..1953
		Edgar S. Weaver, M. D., Carrollton....1953

## KENTUCKY PHYSICIANS MUTUAL, INCORPORATED

## STATEMENT OF FINANCIAL CONDITION AS OF AUGUST 31, 1951

## ASSETS

Cash—in Banks .....	\$266,499.47
Accounts Receivable	
Dues in Process of Collection .....	27,876.99
Investments	
U. S. Government Bonds.....	99,093.75
Total Assets .....	\$393,470.21

## LIABILITIES

## Accounts Payable

Blue Cross Hospital Plan.....	7,716.43
Unreported and Unpaid Cases (Estimated).	
Surgical and Medical	
Benefits .....	100,000.00
Maternity Benefits .....	33,000.00
	133,000.00

## Deferred Income

Unearned Premiums .....	62,478.60
Dues Paid in Advance.....	4,433.50
	66,912.10

Total Liabilities .....	\$207,628.53
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## RESERVES

Unassigned Surplus .....	185,841.68
Total Liabilities and Reserves.....	\$393,470.21

**SPEAKER HOUSTON:** I accept the report of the Kentucky Physicians Mutual, and the supplemental report has been referred to Reference Committee number 3 for their study, and we will take it up at our Wednesday night session.

I have been advised that the Council's action on the Legislative Committee should have been referred to Reference Committee number 1 because it takes up the responsibilities of the Council and the officers. I changed that referral in my report.

Now we are ready for new business. Do we have any new business? You will notice the

record which lists any new business and resolutions must be written. Now the announcements that I have to make are that in the morning the General Session, Scientific Session will begin. I feel that we have in store for us a rare treat, the talents of Kentucky, men trained in Kentucky, brought to us for a very strong scientific program. I trust that our attendance to these sessions will be extremely heavy. I also want to call your attention to the fact that Reference Committees will meet tomorrow afternoon at 1:45 at the back of this room, before we go into the session at 2:00 o'clock to handle the resolutions and reports that have been assigned to them tonight. I would also

like to read the list of officers that will be elected by this House of Delegates on Wednesday night so that you can be giving some thought to these positions and can counsel with the various nominating committees to see that proper personnel is placed in the positions for which officers must be elected. The President-Elect will be elected from Western Kentucky, three vice-presidents from Central, Eastern, and Western Kentucky. The delegates to the A.M.A. and a delegate to finish out this year for A.M.A., alternate delegates to A.M.A., Orator in Surgery, Orator in Medicine, Councilor for the Sixth District and Councilor for the Eighth District and Councilor from the Fifteenth District. I now wish to ask that all nominating committees meet in this hall after the adjournment of this meeting so that we can go over the regulations for the presentation of names for the various offices to be elected.

I have been informed that Dr. Howard wishes to make a report on the matter of dues tonight. Dr. Howard.

DR. HOWARD: Mr. Chairman, this is a resolution that was passed by the Council this afternoon, and it involves all of us because it involves money.

#### RESOLUTION

WHEREAS, the Council made a careful survey and exhaustive study of methods and measures necessary to elevate the services of this Association to its members and the public to a comparable level enjoyed by progressive sister medical associations, and

WHEREAS, a program looking toward the accomplishments of the aims of the Association has been established and is now in operation, and

WHEREAS, the publishing of an improved State Medical Journal, the carrying out of our legislative program and the operation of our present program entails considerable expense, and

WHEREAS, the Association seeks to promote the best possible individual and public health and to maintain vigorous opposition to the encroachment of socialism, and

WHEREAS, the expense involved in the development and operation of this program is causing the Association to operate at a deficit of approximately \$12.50 per member per year, therefore be it

RESOLVED that the Council of the Kentucky State Medical Association recommends to the House of Delegates that the dues of the active members of the Association be raised from \$15.00 to \$25.00 a year.

SPEAKER HOUSTON: I accept this sup-

plementary report and refer it to Reference Committee number 1 for discussion. Any discussion on this dues problem will please be carried to that Reference Committee. Now I have a final tally on the J. Watts Stovall Award, Dr. Kincheloe 62, Dr. Coblin 46. Dr. Kincheloe will be our award winner. We have a total vote in this tally of 108.

Now to recapitulate, for the Distinguished Service Award we have chosen Dr. Carl Norfleet; for the E. M. Howard Award, Dr. J. B. Lukins; and for the J. Watts Stovall Award, Dr. John Kincheloe.

I feel that our House of Delegates is very fortunate tonight to have in our midst the Secretary and General Manager of the A.M.A. We have asked Dr. Lull if he will address us at this time and he has kindly consented to do so. Dr. Lull, will you speak to the House?

(All delegates stand and applaud.)

DR. LULL: Mr. Speaker, Members of the House, I deem it an honor to be allowed the privilege of the floor of the house. I come to the meetings of the Kentucky State Society so often that I suppose I should receive a bill for dues. I thoroughly enjoy them. I have attended some of your meetings today. I saw the Centennial number of your Journal, which is excellent. I notice in glancing hurriedly through it that at least two of your presidents left the state after they served as president and went up to my state to live, two I recognized, Drs. Rutt T. Gross and J. W. Holland.

There are a lot of things that bother the parent association. Practically the same things bother the state associations. For instance, the question of dues. Now as a matter of fact the American Medical Association House of Delegates reduced the dues this year because last year the dues were \$25 and they were dues. This year the dues are \$25 and for the \$25 each member receives fifty-two issues of the Journal of the American Medical Association. The fifty-two issues cost the Association \$13.52 without the mailing charges, so that you see the dues in the Association were really reduced to about \$10 a year.

I am sorry that so many Kentucky physicians have seen fit to remain out of the Association, and I hope that you delegates from the various counties can do a little missionary work because we need their support and they need us.

I am sure that as time goes on this difference between the number of members of the state society and the parent body will be reduced.

Now we have had, as Dr. Hancock told you, some trouble about hospital standardization. Now this was a very serious thing, and it was



extremely serious because had it gone on the way it started it would mean that the standardization of hospitals would be completely under the control of the hospital group, which is not at all right, and they have ruled that anything that was controlled by the board of trustees could be standardized by them. Now if you know anything in a hospital that isn't controlled by the board of trustees, I don't know what it is. Eventually the board of trustees control it because they are the ones who furnish the funds. Our committee, headed by your own Dr. Henderson, met a great many days, worked all day with the hospital group and with the College of Physicians and with the College of Surgeons, and the meetings were friendly—sometimes the arguments got a little heated, but they all calmed down later in the day and I think we have a working method of hospital standardization. It has been approved by all of the parent organizations except the American Hospital Association, and they will meet shortly and undoubtedly will approve it.

Then we have the question of aid to medical education. We have seen fit as an association through the action of our Legislative Committee, our trustees, and our House of Delegates to go on record as not being in favor of federal aid to medical education because we are afraid that with the subsidy there would go eventually control of medical education, and we think that would be very unwise. When I say "we," I am talking about the Association as a whole in which you are included just as much as anyone else because after all it is your association. Now the medical schools do need money. State supported schools should be able to get the money from state legislatures, and they should have all the help possible from medical societies to see that they get adequate funds from state legislatures. Private schools in some states can obtain no help from state legislatures. In many states they can. In Pennsylvania, for instance, for years the state legislature has been paying money to the schools on a per capita basis, and there is no state medical school in the state of Pennsylvania. They are all private schools, including the University of Pennsylvania.

Now the American Medical Association has given a half million dollars to a fund. Now this fund is going to be a recurring fund and we would like to have it augmented by the physicians all over the country who could give any amount that they saw fit to this fund yearly. They can ear-mark it for any school that they wish. If they want it to go to their own medical school, they can so ear-mark it. We believe that the foundation can raise a certain amount of money from industry and

perhaps get some from some of the foundations. Now this money is not in the amount asked for by the people who would pass bills or who would propose bills for federal aid to education by granting millions of dollars to the medical schools, but any dean who gets a check from ten to twenty-five thousand dollars and fifty thousand dollars—and this year it was over ten thousand dollars—gets it on his desk and he is told, "Here is a check. You can do just as you please with it," that I think—and I have talked with several deans—they say that that will pay an instructor's salary for a year and if we can give three times that much it will be three instructors' salaries, or if he needs equipment it will pay for a considerable amount of equipment.

We have still the trouble of legislation not being forced upon us in any one bill, but sneaked into bills as riders and as paragraphs and as hidden paragraphs. That is, the paragraph is there, but unless you don't see the implications. These are the things that we have to watch for on the federal level, and I imagine you people will also have to watch for them on the state level. I told the Legislative Committee about one that was introduced into the universal training bill. It was introduced and it was a very simple two sentences. It said any rejected draftee, any rejected trainee who could be rehabilitated physically or educationally by the direction of the President of the United States through agencies already established—well, that would mean that the rehabilitation section of Mr. Ewing's office could be enlarged to take in every disabled man who is physically handicapped, and that all of the illiterates could be sent to schools and have schools opened for them throughout the United States. It was just a little joker taken out of the bill, but it was taken out of the bill because of the American Medical Association asking to have it taken out, and we were the only organization or individual who appeared against that provision. No other individual or organization appeared against that except the American Medical Association.

Now there has been a lot of political talk about introducing a bill into Congress to hospitalize all people over sixty-five at government expense. You have heard that thrown out. We have done nothing about it, because no bill was introduced, but undoubtedly there will be a bill introduced in Congress. You say that's a nice thing to do. It's an awfully difficult thing to do, tell the people in the United States over sixty-five they will get their hospitalization free, and if you come out and say you are against it, why you will be criticized again for being against the poor

downtrodden individual over sixty-five years of age.

Well, I could go on here. There are many things that our organization has had to be cognizant of and has had to be on guard against, and I think we are better organized than we ever were before to guard against those things.

There is one thing that I want to apologize about from headquarters, and that is the matter of subscription to the Journal and dues. Now I know there are men in this room who have trouble getting their Journal, but if you will just think that in two years the House of Delegates changed the ground rules on us three times and our system was an old system in that it was run by individual cards, there was bound to be some mix-up in the department. Furthermore, I don't know of any place or any organization where in December when the House of Delegates said, "Each member will receive the Journal free," and who are the members at the first of the year? No one had paid his dues at the first of the year, and we were supposed to send the Journal to all members who paid their dues. Some of the dues were not paid for months later. We had to simply guess at it, and we sent the Journal to members who had paid their dues for 1950. So if a man didn't pay his 1951 dues he probably got the Journal, and some of them are still getting it, but it was just one of those things that is almost impossible to handle. You don't subscribe to magazines in that way. When you subscribe to a magazine you subscribe for a year and at the end of the year you stop getting it if you don't pay for it. We have several thousand subscriptions that come in from non-members that are handled that way, but with the members we were just up against it and had to take a chance. Now this year postal rates are going up. Paper has gone up in the last two years three times. Our bill for paper now is over three quarters of a million dollars a year, so that all this is expensive.

When Dr. Howard spoke about the fifty cent dollar he is absolutely right. I have told the story very often about after World War I in the minutes appears a minute, "Dr. Simmons in talking about the great expense of headquarters said that it was almost impossible to get a clerk in headquarters at \$18 a week," and now of course you know if you have a part-time office boy you are paying him that. However, the parent association is in excellent shape, and even with the fifty-cent dollar we have now over eight hundred employees. Every time the House of Delegates meets they plan some other activity, and that means more employees. Student American

Medical Association, which has gone off very well, means that we had to take on some more employees to manage it, only two or three, but two or three here and there soon add up and we have an enormous corporation. You people are stockholders in this corporation, which does a business of \$5,000,000 a year, and I think you people should have some interest in it.

When I go to a state society, I always request that when any member comes to Chicago, will he come to headquarters and let us show him what we are doing there; it is his organization and we will welcome every one of you and will attempt to show you what we do with your money. Thank you very much. (Applause.)

**SPEAKER HOUSTON:** Thank you, Dr. Lull, it has been good to have you with us at this meeting, and I assure you you have a standing invitation to return to our meetings year after year.

May I call your attention to the fact that we have 114 registered tonight, 23 officers and 91 delegates. I also wish to remind you of the 1:45 meeting tomorrow afternoon of the reference committees in the rear of this room before they go to their respective committee rooms in the basement of this building. I want to remind you that the nominating committees are to meet in this hall just after adjournment, and your nominating committees for our councilors made up of the delegates from those county districts who have elections this year—that is, the Sixth District, Eighth District, and the Fifteenth District—and then we have our regular Nominating Committee.

Dr. Baughman would like to meet with the members of the Seventh Councilor District in the rear of this room at the left side just following the meeting.

We would like to have the nominating committee from the Sixth District here tonight for their instructions, and if they care to meet with Dr. Howard Wednesday afternoon that will be straightened out.

The Chair has no more business. We will now receive a motion for adjournment.

(A motion was so made, was regularly seconded, was put to vote and carried.)

(Thereupon the meeting was adjourned.)

## SECOND SESSION

Columbia Auditorium  
Louisville, Kentucky  
October 3, 1951

The second session of the meeting of the House of Delegates was called to order at 7:00 o'clock p.m., at the Columbia Auditorium, in Louisville, Kentucky, Speaker Hugh L. Houston presiding.



SPEAKER HOUSTON: May I call the House to order?

It is now my privilege to call the second session of the House of Delegates of 1951 to order.

I would like now to have the final report of the Committee on Credentials. I think Dr. Coleman is giving that report.

DR. FOSTER D. COLEMAN: The credentials are in order, and a quorum is present.

SPEAKER HOUSTON: May I have a motion from the floor to proceed?

(A motion was so made and was regularly seconded. The motion was put to vote and carried.)

SPEAKER HOUSTON: So ordered. We will now have the final report of the Council. Dr. C. C. Howard.

DR. HOWARD: Gentlemen, I have to get up here and talk a little bit about money.

#### RESOLUTION OF THE COUNCIL OF THE KENTUCKY STATE MEDICAL ASSOCIATION

WHEREAS, certain expenses have been incurred in the development and carrying out of this Centennial Meeting, which must be paid, and

WHEREAS, a very considerable number of officers and members of the Association, along with the Headquarters Staff, have participated in the promotion and development of the Centennial Meeting, therefore

BE IT RESOLVED that the House of Delegates authorize the payment of these bills and instruct the Secretary and General Manager to express the appreciation of the Association to all those who have had a part in its fulfillment.

DR. HOWARD: I move the adoption of this resolution.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

While we are waiting for the others to be prepared, we will go to the next item of business. We are ready for the reports of the reference committees who studied all the resolutions you men brought before the committee.

Committee Number 1 is composed of E. M. Howard, Harlan, Chairman; Thomas V. Gudex, Louisville, Vice-Chairman; Luther Bach, Newport; Theodore L. Adams, Lexington; Robert L. Reeves, Paducah. A report of the order and rules of business and reports of officers and councilors of the Association. I will now ask Dr. Howard to present their report. Dr. E. M. Howard.

DR. E. M. HOWARD: We worked on that

reference committee yesterday from two o'clock until about five-twenty. It was a painstaking job, and we tried to concentrate this in a very short report, and I hope it will not be long enough to bore you.

#### REPORT OF REFERENCE COMMITTEE NO. 1 TO THE 1951 HOUSE OF DELEGATES

Reference Committee No. 1 met on Tuesday, October 2, at 2:00 P.M. All members were present. The following reports were read and accepted: Report of the Speaker of the House of Delegates, Report of the President-Elect, Report of the Legislative Committee, Resolution of the Council of the Kentucky State Medical Association, Report of the President, Report of the Treasurer, Report of the First Councilor District, Report of the Second Councilor District, Report of the Third Councilor District, Report of the Fourth Councilor District, Report of the Fifth Councilor District, Report of the Sixth Councilor District, Report of the Seventh Councilor District, Report of the Eighth Councilor District, Report of the Ninth Councilor District, Report of the Tenth Councilor District, Report of the Eleventh Councilor District, Report of the Twelfth Councilor District, Report of the Thirteenth Councilor District, Report of the Fourteenth Councilor District, Report of the Fifteenth Councilor District, and herewith approve and respectfully request the adoption and filing of these reports.

The Report of Delegates to the American Medical Association was read and considered and accepted with the exception that on Page 2, paragraph 1, the language be changed as follows: instead of "your delegates recommend that The Council of the State Medical Association be directed to make an appropriate contribution to the American Medical Education Foundation for this fund," substitute instead "your delegates recommend that the Council of the State Medical Association be requested to consider making an appropriate contribution to the American Education Foundation for this fund."

The Report of the Council has been read and considered and approved and recommended for approval and filed, except on Page 10 of this report, and in paragraph 3 thereof, the Council recommended the acceptance of a recommendation by Dr. Underwood that a deadline for county societies submitting delegates to the Headquarters Office eligible for serving on the reference committees at the Annual Meeting be made as of April 1st. This Committee believes that date should be extended to August 1, in lieu of April 1.

Thomas V. Gudex, Louisville  
Luther Bach, Newport

Theodore L. Adams, Lexington  
Robert L. Reeves, Paducah  
E. M. Howard, Harlan, Chairman

DR. E. M. HOWARD: I make a motion that this report of Reference Committee Number 1 be submitted, approved and filed.

SPEAKER HOUSTON: I have a motion. Do I have a second to Dr. Howard's motion?

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: It is so ordered.

We are now ready for the report of Reference Committee Number 2. The first delegate of this committee is W. Vinson Pierce, Covington, Chairman. The others on the committee are Ralph L. Cash, Princeton; Herbert L. Clay, Jr., Louisville; Robert A. Orr, Mayfield; Rankin Blount, Lexington.

We will now hear from Dr. Pierce.

DR. W. VINSON PIERCE: Your Reference Committee Number 2 has reviewed the following reports and has recommended that each of these reports be accepted as submitted, without revision. Is it the wish of the Chair or the Floor that we submit these separately? Or otherwise, we will submit them as a whole.

SPEAKER HOUSTON: Your pleasure, sir.

DR. PIERCE: In that event, the Committee submits the following report.

#### **REPORT OF REFERENCE COMMITTEE NO. 2 TO THE 1951 HOUSE OF DELEGATES**

Your Reference Committee No. 2 has reviewed the following reports: Report of Committee on Scientific Assembly; Report of the Committee on Arrangements; Report of the Committee on Medical Education; Report of the Medico-Legal Committee; Report of the Committee on Medical Economics; Report of the Committee on Public Relations; Report of Education Campaign Subcommittee; Report of Committee on Technical Exhibits; Report of the Committee on Scientific Exhibits.

The Committee recommends that each of these reports be accepted as submitted.

Ralph L. Cash, Princeton  
Herbert L. Clay, Jr., Louisville  
Robert A. Orr, Mayfield  
Rankin Blount, Lexington  
/s/ W. V. Pierce  
W. Vinson Pierce, Covington,  
Chairman, Reference Committee No. 2

DR. PIERCE: Mr. Chairman, I move the adoption of these reports as submitted.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

Now we are ready for the report of Reference Committee No. 3, which was to study the reports of the special committees. The personnel was Dr. Walter L. O'Nan, Henderson, Chairman; Dr. Richard J. Rust, Newport, Vice-Chairman; Dr. Arthur R. Kasey, Louisville; Dr. Keith P. Smith, Corbin; Dr. B. Ralph Wilson, Sharpsburg.

We will hear from Dr. O'Nan.

DR. WALTER L. O'NAN: I move the adoption of this section of the report studied by Reference Committee No. 3: The Committee on Centennial Meeting.

Mr. Chairman, would you like these separated?

SPEAKER HOUSTON: It is your pleasure, sir.

DR. O'NAN: I move the adoption of this section of the report:

#### **REPORT OF REFERENCE COMMITTEE NO. 3 TO THE 1951 HOUSE OF DELEGATES**

Mr. Chairman, I move the adoption of this section of the report: Committee on Centennial Meeting.

Mr. Chairman, I move the adoption of this section of the report: Diabetic Committee.

Mr. Chairman, I move the adoption of this section of the report: Committee on Emergency Medical Service.

Mr. Chairman, I move the adoption of this section of the report: Committee on Hospitals.

Mr. Chairman, I move the adoption of this section of the report: Kentucky State Advisory Committee to Selective Service.

Mr. Chairman, I move the adoption of this section of the report: K.S.M.A.-Dental Committee.

Mr. Chairman, I move the adoption of this section of the report: K.S.M.A.-Pharmacy Committee.

Mr. Chairman, I move the adoption of this section of the report: Board of Directors of McDowell Memorial Foundation.

Mr. Chairman, I move the adoption of this section of the report: Committee on Nurse Training.

Mr. Chairman, I move the adoption of this section of the report: Professional Relations Committee.

Mr. Chairman, I move the adoption of this section of the report: Committee to Study the Constitution and By-Laws.

Mr. Chairman, I move the adoption of this section of the report: Supplementary Report of the Committee to Study the Constitution and By-Laws.



Mr. Chairman, I move the adoption of this section of the report: Committee on Training of Ambulance Attendants.

Mr. Chairman, I move the adoption of this section of the report: Board of Trustees of the Rural Kentucky Medical Scholarship Fund (the Reference Committee strongly endorses the publicity of the first paragraph of this report.)

Mr. Chairman, I move the adoption of this section of the report: Medical Research Commission.

Mr. Chairman, I move the adoption of this section of the report: President of the Woman's Auxiliary to the Kentucky State Medical Association.

Mr. Chairman, I move the adoption of this section of the report: Board of Directors of Kentucky Physicians Mutual, Inc.

Mr. Chairman, I move the adoption of this section of the report: Nominations for the Board of Directors of the Kentucky Physicians Mutual, Inc.

Mr. Chairman, I move the adoption of the reports as a whole.

Richard J. Rust, Newport  
Arthur R. Kasey, Louisville  
Keith P. Smith, Corbin  
B. Ralph Wilson, Sharpsburg  
/s/ Walter L. O'Nan  
Walter L. O'Nan, Henderson,  
Chairman, Reference Committee  
No. 3

SPEAKER HOUSTON: I have a motion. Do I have a second?

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

We will now have the report of Reference Committee No. 4, who studied the reports of the Advisory Committees. The Committee is composed of George W. Pedigo, Louisville, Chairman; Frank L. Duncan, Monticello, Vice-Chairman; Leon Higdon, Paducah; Harry K. Dillard, Warsaw; H. B. Mack, Pewee Valley.

We will have Dr. Pedigo, please.

DR. GEORGE W. PEDIGO: Mr. Speaker, members of the House of Delegates, your Reference Committee No. 4 met on Tuesday afternoon and studied the reports of the Advisory Committee, and we have the following report to make:

#### REPORT OF REFERENCE COMMITTEE NO. 4 TO THE 1951 HOUSE OF DELEGATES

Your Reference Committee on the reports of Advisory Committees has the following report to make:

1. Report of Committee on Cancer.

2. Report of Committee on Crippled Children.

3. Report of Committee on General Practice.

4. Report of Committee on Industrial Medicine and Surgery.

5. Report of Committee on Mental Hygiene and Mental Institutions.

6. Supplemental Report to the Report of Committee on Mental Hygiene and Mental Institutions.

7. Report of Committee on Obstetrics.

8. Report of Committee on Pediatrics.

9. Report of Committee on Physical Therapy.

10. Report of Committee on Rural Health.

11. Report of Committee on Syphilis Control.

12. Report of Advisory Committee to Woman's Auxiliary.

13. Report of Committee on United Mine Workers Health and Welfare Fund.

These reports have been reviewed and found satisfactory as read.

Mr. Speaker, I move the adoption of these reports as submitted.

SPEAKER HOUSTON: I have a motion. Do I have a second?

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PEDIGO: The Report of the Committee on Tuberculosis was reviewed. The report was found to be satisfactory with the exception of the last sentence under Recommendation Number Two, Page One, which reads, "We recommend that the Kentucky State Medical Association endorse this case-finding program on a statewide basis, with no counties excepted." The committee recommends that the words, "with no counties excepted," be deleted. Under Recommendation Number Three, Page One of the Report of the Committee on Tuberculosis headed, "Follow-up X-Rays," which reads, "Screening surveys lose value in direct proportion to the number of persons who should have a large film follow-up but fail to get it. In accordance with the policy already adopted by many states, municipalities, and the U. S. Public Health Service, we recommend that in all chest x-ray surveys the large film follow-up where indicated be made an integral part of the case-finding program without expense to the patient," our committee recommends that this paragraph be changed to read as follows: "Screening surveys lose value in direct proportion to the number of persons who should have a large film follow-up but fail to get it. We recommend that in all chest x-rays surveys the large film follow-up where indicated be made an integral part of the case-finding program

without expense to the indigent patient. If the patient is able to pay he should be referred to his private physician for follow-up x-rays when adequate facilities are available."

The Supplemental Report of the Committee on Tuberculosis was reviewed. The report was found to be satisfactory with the exception of the last sentence in Paragraph Three, Page Two, which reads as follows: "It is recommended that all hospitals having x-ray equipment adopt a policy of routine chest x-rays on all admissions." Our committee recommends that this sentence be deleted.

Mr. Speaker, I move that the report of the Committee on Tuberculosis and the Supplemental Report of the Committee on Tuberculosis be adopted as amended.

Frank L. Duncan, Monticello,  
Vice-Chairman

Leon Higdon, Paducah

Harry K. Dillard, Warsaw

H. B. Mack, Pewee Valley

George W. Pedigo, Louisville,

Chairman, Reference Committee  
No. 4

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

We will have the report of Reference Committee No. 5, New Business and Resolutions Committee. It is made up of the following personnel: Charles B. Stacy, Pineville, Chairman; Howell J. Davis, Owensboro, Vice-Chairman; James A. Outland, Murray; John D. Handley, Hodgenville; John W. Scott, Lexington.

The Secretary did not receive the resume of new business for this committee to work on, and I thank them for being on their post of duty without business to handle.

Now we come to the place in the order of business for other unfinished business, and Dr. Howard now has a second resolution.

DR. C. C. HOWARD: As you know, one of the purposes of the Centennial Meeting was to honor medical leaders of the past. I offer the following resolution:

#### RESOLUTION

WHEREAS, one of the purposes of the Centennial Meeting was to honor medical leaders of the past, and

WHEREAS, in order to pay our respects to the most prominent medical pioneer in Kentucky, the meeting has been designated as the Ephraim McDowell Meeting, and

WHEREAS, the Woman's Auxiliary to the K.S.M.A. gave much time, thought and effort in honoring Dr. McDowell through the pre-

sentation of important periods of his life by means of a beautifully presented tableau at the General Public Meeting, therefore,

BE IT RESOLVED that the Secretary of our Association express the appreciation of the membership to the Woman's Auxiliary for the splendid contribution that they have made to the success of our Centennial Meeting.

DR. HOWARD: That is a motion.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

Is there any other unfinished business? (No response.) If there is no other unfinished business, we will now have the election of officers.

We have to elect tonight the following officers: President-Elect, three Vice-Presidents, delegate to the American Medical Association for two years beginning next January 1st; alternate delegate for the unended term of one year, full term of two years, and the unended term of two months to January 1st, 1951. We have to elect an orator in surgery, orator in medicine, councilor from the Sixth District, councilor from the Eighth District, and councilor from the Fifteenth District.

Last year, you allowed the Chair the privilege of using a one-page ballot and the Chair wishes again to secure the approval of this method, if you wish to give it. You will hold the ballot until the end of the various nominations. You will put in your vote. We will take them up and count the votes and re-vote all the contest offices.

(A motion was made to allow the President the privilege so mentioned. The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: I will now appoint the tellers for the evening. I will ask is Dr. M. C. Loy of Columbia here? Dr. John W. Meredith of Scottsville? Is Dr. R. N. Lawson of Lawrenceburg here? Is Dr. William C. Wells of Glasgow here?

Dr. Loy, Dr. Meredith, and Dr. Wells will be my tellers.

As the members of the House of Delegates know, we have a nominating committee composed of William L. Woolfolk, Owensboro, Chairman; Clyde Sparks, Ashland; Joseph Bowen, Louisville. Dr. Woolfolk is the Chairman of this committee, and I will now ask him to give you the nominations, one or more, for the office of President-Elect. It is understood that the President-Elect will come from Western Kentucky this year. We will now have that nomination.

DR. WOOLFOLK: Mr. Speaker, your nominating committee composed of Dr. Clyde



Sparks of Ashland, Dr. Joseph Bowen of Louisville, and Dr. William Woolfolk, respectfully submit the following names for officers of your Association.

SPEAKER HOUSTON: Dr. Woolfolk, may I just have the President-Elect first?

DR. WOOLFOLK: As Chairman, I wish to place in nomination for President-Elect, Dr. R. Haynes Barr of Owensboro.

SPEAKER HOUSTON: The Chair has the nomination of Dr. R. Haynes Barr. Do I have a second to that nomination?

(The nomination was regularly seconded.)

SPEAKER HOUSTON: Do I have a nomination from the floor?

(No response.)

SPEAKER HOUSTON: Do I have a motion that nominations cease?

(A motion was so made, was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: I will ask that you mark your ballots for Dr. R. Haynes Barr for President-Elect.

DR. WOOLFOLK: As Chairman, I wish to place in nomination for Vice-President, Dr. Keith Smith, of Corbin.

SPEAKER HOUSTON: Do I have a second to the nomination of Dr. Keith Smith of Corbin?

(The nomination was regularly seconded.)

SPEAKER HOUSTON: Do I have any nominations from the floor?

A VOICE: Where is this from? What part of Kentucky?

SPEAKER HOUSTON: Eastern Kentucky. Is that straight now?

DR. WOOLFOLK: Would you like for me to read the three Vice-Presidents and add additional ones if you want?

SPEAKER HOUSTON: I thought I'd take each section of the State, if it was satisfactory.

DR. WOOLFOLK: Dr. Smith is from Eastern Kentucky.

(A motion was made that nominations cease. The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: Dr. Keith Smith will be our Vice-President from Eastern Kentucky. We will now have the Vice-President from Louisville.

DR. WOOLFOLK: I wish to place in nomination as Vice-President from Louisville, the name of Dr. Thomas Van Zandt Gudex.

SPEAKER HOUSTON: Do I have a second to Dr. Gudex's nomination?

(The nomination was regularly seconded.)

SPEAKER HOUSTON: Do I have another nomination from the City of Louisville, from the floor?

(A motion was made that nominations cease.)

SPEAKER HOUSTON: I have a motion that nominations cease. Do I have a second?

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: We will have the nomination for the Vice-President from Western Kentucky.

DR. WOOLFOLK: As Chairman, I wish to place in nomination Dr. R. Ward Bushart from Fulton, Kentucky.

SPEAKER HOUSTON: I have the nomination of Dr. Bushart from Fulton. Do I have a second?

(The nomination was regularly seconded.)

SPEAKER HOUSTON: Do I have other nominations from the floor for Vice-President from Western Kentucky?

(A motion was made that nominations cease. The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: Dr. R. Ward Bushart will be our Vice-President from Western Kentucky.

Now we are ready for the delegate, A.M.A., beginning January 1st, 1952.

DR. WOOLFOLK: As Chairman, I wish to place in nomination as delegate to the A.M.A. for two years beginning January 1, 1952, the name of Dr. Bruce Underwood of Louisville.

SPEAKER HOUSTON: I have the name of Dr. Bruce Underwood, from Louisville. Do I have a second to that nomination?

(The nomination was regularly seconded.)

SPEAKER HOUSTON: Do I have a nomination from the floor?

(A motion was made that nominations cease. The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered. We are now ready for the alternate delegates, for the A.M.A. delegates. We have three alternate delegates to elect.

A VOICE: What about the short term?

DR. WOOLFOLK: As Chairman, I wish to place in nomination as alternate delegate for Dr. J. B. Lukins, to serve until January 1, 1952, the name of Dr. Henry Asman of Louisville.

SPEAKER HOUSTON: I have the name of Dr. Henry Asman. Do I have a second to the nomination?

(The nomination was regularly seconded.)

SPEAKER HOUSTON: Do I have any nom-

inations from the floor?

(A motion was made that nominations cease. The motion was regularly seconded, was put to vote and carried.)

**SPEAKER HOUSTON:** So ordered. Dr. Henry Asman will be alternate for Dr. Lukins until January 1, 1952.

**A VOICE:** We are mixed up, on the A.M.A. short term.

**DR. WOOLFOLK:** That is the short term. He will serve as alternate until January 1, 1952. He is alternate for Dr. Lukins.

**DR. SCOTT:** Mr. President, you have a line there, "alternate delegate to A.M.A., short term." That's identical with a line below where you have, "delegate to A.M.A., short term." Are there two alternate delegates for the short term?

**SPEAKER HOUSTON:** Dr. Underwood will attempt to straighten that out.

**DR. UNDERWOOD:** Mr. Speaker, members of the House: The delegate to the A.M.A. for the full term begins on January 1, 1952. The delegate to the A.M.A. short term which is listed next on your ballot—there should be a nomination for that position. That's the present term which will expire—the present term of the third delegate. It's the one which I now fill. And Dr. Woolfolk, I believe, has a letter from Dr. Lovell on that particular matter. That's what is confusing the issue here. Then you will see three alternate delegates. You see, we have three delegates to the A.M.A. in January of this year. After January 1st, we will only be entitled to two delegates, the reason being that the American Medical Association changed their rules to read that only dues-paying members should be used in order to calculate the number of delegates. They allowed one for each one thousand members. We have close to fourteen hundred members, which would entitle us to two delegates. We'd have to have two thousand and one dues-paying members to the A.M.A. before we would again have three delegates.

**SPEAKER HOUSTON:** Is there any other question now?

**A VOICE:** What did you elect Asman to?

**SPEAKER HOUSTON:** We elected him to the alternate J. B. Lukins term, which, if I understand correctly, ends January 1, 1952.

**A VOICE:** A short term?

**SPEAKER HOUSTON:** Yes.

**DR. SCOTT:** Why is he put down here as a delegate on this form if he is an alternate?

**DR. UNDERWOOD:** Mr. Speaker, we have three delegates to the A.M.A. to serve until January, 1952. One is Dr. J. B. Lukins. One

is Dr. J. D. Hancock. One is the term for which the council appointed me pending action by the House of Delegates. The council felt that they had only the right to appoint the third delegate until the House of Delegates met. Just three days ago, Dr. Elmer Henderson pointed out that if the House of Delegates elected anybody else for the third delegate this year, that A.M.A. would not recognize it because their rules and by-laws say that once a member is elected for a delegate, he cannot be changed during that year. That is the term which is in dispute, I believe.

**DR. WOOLFOLK:** I am going to ask Dr. Underwood to interpret what delegate Dr. Asman has been elected to.

**A VOICE:** Then our ballot is in error in that we are not electing a short term delegate?

**DR. UNDERWOOD:** You have two choices, Dr. Pierce. Before you get to the alternate delegate, you should clear the election of the delegates, before you get to the alternate delegates. The American Medical Association says that since you have elected the delegates, that they will have to serve until January 1, 1952, and that if you change any of the delegates that are now serving, which means if you were to reverse the action of the council, then that delegate would not be recognized by A.M.A. That's their ruling. It's certainly not mine. I take it it would be in order for the House either to vote to take it off the ballot or to confirm the action of the council.

**A VOICE:** May I make a suggestion: Can you coincide the ballot with your nominations?

**DR. WOOLFOLK:** I believe, Mr. Speaker, if you will let us proceed with the nominations of the Nominating Committee, the whole thing will become clear to us. In other words, each delegate must have an alternate to back him up, and I think if we proceed, you will see that that has been taken care of.

**SPEAKER HOUSTON:** Will the Chairman of the Nominating Committee be allowed to proceed?

(A motion was so made, was regularly seconded, was put to vote and carried.)

**DR. WOOLFOLK:** It was the intention that Henry Asman should be alternate to Dr. J. B. Lukins whose term expires January 1, 1952, and that, I believe, you have just elected Dr. Asman to. The Chairman of the Nominating Committee wishes to place in nomination for alternate for Dr. Duffy Hancock, whose term expires the last day of December, 1953, the name of Dr. C. C. Howard, of Glasgow.

**SPEAKER HOUSTON:** I have the nomination of Dr. C. C. Howard. Do I have a second? (The nomination was regularly seconded.)



DR. WOOLFOLK: I make a mistake. Dr. Hancock's term expires the last day of December, 1952.

SPEAKER HOUSTON: Do I have any other nominations for this alternate position? That is, alternate to Dr. Duffy Hancock, which would expire at the end of Dr. Hancock's term.

(A motion was made that nominations cease. The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. WOOLFOLK: Mr. Speaker, as Chairman, I wish to place in nomination as alternate for Dr. Bruce Underwood, whose term will expire at the end of December, 1953, the name of Dr. W. Vinson Pierce, of Covington.

SPEAKER HOUSTON: I have the nomination of Dr. Pierce for alternate for Dr. Underwood. Do I have a second?

(The nomination was regularly seconded.)

SPEAKER HOUSTON: Do I have any nominations from the floor?

(A motion was made that nominations cease. The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

Give me the Orator in Surgery.

DR. WOOLFOLK: As Chairman, I wish to place in nomination for Orator in Surgery, the name of Dr. Gaithel L. Simpson of Greenville.

SPEAKER HOUSTON: I have the nomination of Dr. Gaithel L. Simpson of Greenville. Do I have a second?

(The nomination was regularly seconded.)

SPEAKER HOUSTON: Do I have other nominations from the floor?

(A motion was made that nominations cease. The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

Now, Orator in Medicine.

DR. WOOLFOLK: As Chairman, I wish to place in nomination the name of Dr. Joseph M. Bush of Mt. Sterling.

SPEAKER HOUSTON: I have a nomination of Dr. Joseph M. Bush from Mt. Sterling for Orator in Medicine. Do I have a second?

(The nomination was regularly seconded.)

SPEAKER HOUSTON: Do I have any nominations from the floor?

(A motion was made that nominations cease. The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered. Dr. Bush will be our Orator in Medicine for the next year, and Dr. Simpson will be our Orator in Surgery.

Thank you, Dr. Woolfolk.

Is there any question about the office of delegate to the American Medical Association?

A VOICE: I just want to know how to check this space on this ballot.

DR. WOOLFOLK: I'm sorry. The Nominating Committee did not see the ballot in making up the list of men for the nominations, but I think if you will follow me, that each delegate is now backed up by an alternate, during their entire term, which I think takes care of it.

DR. SCOTT: I'd like to ask for information in regard to the selection of the orators in surgery and medicine. It has been the custom from time immemorial, until the last year or two, to select an orator in medicine from, I think, Louisville one year, and an orator in surgery from out in the State that year, and then to reverse that system. Now, Louisville isn't represented on here. I think the men who have been here a good many years will remember that has been the custom heretofore. Of course, there is nothing in the Constitution and By-Laws to support that. It is one of those customs that has grown up, much like that of selecting the President from the three sections of the State in rotation. This is already an accomplished thing, so it doesn't affect this at all, but I am just asking for information, and for guidance in the future, regarding whether or not that has been the custom for many years.

SPEAKER HOUSTON: Dr. Scott, the Speaker is not familiar with that custom, but I think the subject is certainly open to discussion, if somebody wants to discuss it. Is there any other discussion from the floor? Dr. Scott wants to clear it for the future.

DR. RICHEY: I know at our meeting, we discussed this thing. It is customary to have an orator in surgery from Louisville. We felt certain that it should be rotated around a little bit more, but we feel no bitterness. However, I do believe it has been customary in the past.

SPEAKER HOUSTON: If there is no more discussion, we will go, then, to the election of the council. We have to elect a councilor from the Sixth District, a councilor from the Eighth District, and a councilor from the Fifteenth District, and as Dr. Barr was elected President-Elect, we will hear from him after the election of these three councilors.

We will now accept the nominations from the Nominating Committee, which is composed of those delegates from the Sixth District, for a councilor from their district. I do not have that name.

DR. DONNELLY (Bowling Green): I'd like to place before the House of Delegates the name of Dr. L. O. Toomey for councilor from the Sixth District.

SPEAKER HOUSTON: I have the nomination of Dr. L. O. Toomey from the Sixth District—Bowling Green. Do I have a second?

(The nomination was regularly seconded.)

SPEAKER HOUSTON: Do I have a nomination from the floor?

(A motion was made that nominations cease. The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: The Chair will now receive nominations for councilor from the Eighth District. I do not know who will place this nomination.

DR. RICHARD J. RUST (Covington): I would like to place in nomination for councilor from the Eighth District, Dr. Edward B. Mersch.

SPEAKER HOUSTON: Do I have a second to that nomination?

(The nomination was regularly seconded.)

SPEAKER HOUSTON: Do I have a nomination from the floor for this position?

(A motion was made that nominations cease. The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: Dr. Mersch will be our councilor from the Eighth District. Now we will have a councilor from the Fifteenth District. Here again, I do not know who is to make the nomination.

DR. CHARLES STACY (Pineville): We wish to place in nomination the name of Dr. Edward Wilson, Sr., of Pineville, Kentucky, as councilor from that district.

SPEAKER HOUSTON: Dr. Edward Wilson, Sr., from Pineville, Kentucky, is our nomination.

(The nomination was regularly seconded.)

SPEAKER HOUSTON: Do I have any nominations from the floor?

(No response)

SPEAKER HOUSTON: Do I hear a motion that nomination cease?

(A motion was so made, was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. WOOLFOLK: Mr. Speaker, as Chairman from the Second District, since Dr. R. Haynes Barr was our councilor and has been elected to the position of President-Elect of this Association, that leaves the Second District without a councilor. I wish to place in nomination the name of Dr. Walter O'Nan of

Henderson for councilor of the Second District.

SPEAKER HOUSTON: Dr. Woolfolk, is it automatic or would Dr. Barr have to resign the councilorship in person?

DR. BARR: Mr. Speaker, I wish to hereby submit my resignation as councilor of the Second District.

SPEAKER HOUSTON: I have the resignation of Dr. Barr as councilor for the Second District. I ask the House to accept the resignation.

(A motion was so made, was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: It is now in order for Dr. Woolfolk to make his nomination.

DR. WOOLFOLK: I wish to place in nomination the name of Dr. Walter O'Nan of Henderson, as councilor for the Second District.

SPEAKER HOUSTON: I have the nomination of Dr. Walter O'Nan as councilor for the Second District. Do I have a second?

(The nomination was regularly seconded.)

SPEAKER HOUSTON: Do I have a nomination from the floor?

(The motion was made that nominations cease. The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: Dr. O'Nan will be our councilor from the Second District.

Now, may I ask that Dr. Aud and Dr. Jackson escort our President-Elect to the stage, please?

(President-Elect R. Haynes Barr was escorted to the platform. The assembly arose and applauded.)

SPEAKER HOUSTON: It is now my pleasure to present to you Dr. R. Haynes Barr of Owensboro, Kentucky. Dr. Barr.

PRESIDENT-ELECT BARR: Mr. Speaker, Mr. President, members of the House of Delegates: This is by far the greatest and finest honor that it has ever been my lot to receive. I am deeply touched and extremely grateful to you, my colleagues, for this expression of your confidence in my ability and in me. I am somewhat awed and appalled by the great responsibilities of the office to which you have seen fit to elect me. I think my awe is somewhat heightened by having observed at close range the exceptional ability and the outstanding caliber of those predecessors of mine within my recent memory.

As President-Elect, I believe my duties for the coming year are twofold: First, to serve an apprenticeship under the direction and leadership of the President of the Association, thereby learning all that it is possible to learn



from him about the operation and the administration of our great medical association. I think that the second duty of the President-Elect is to render all possible service to our President for the coming year.

I believe it would be presumptive for me to express any opinion upon the problems or the needs of this Association. That would be definitely an invasion of the prerogative of Dr. Clark Bailey. However, in passing, I cannot miss the opportunity of asking each and every one of you gentlemen to quietly, within your own consciousness, to pledge with me to Dr. Clark Bailey and the other officers for the coming year our enthusiastic and whole-hearted confidence and our most loyal support. To Dr. Bailey these I myself pledge.

To you gentlemen who have so signally honored me, I pledge within the limits of my own ability, my very, very best. Thank you so much for this expression of confidence.

(Applause)

**SPEAKER HOUSTON:** Does anybody have any announcements? The Chair is through with the business at hand. The order of business has been finished, and I will now take a motion for adjournment.

**DR. SCOTT:** Mr. Chairman, could I arise with a question?

**SPEAKER HOUSTON:** Dr. Scott has requested the privilege of addressing the House.

**DR. SCOTT:** The Fayette County delegation was instructed to oppose the action of the proposal of the council to increase the dues of the Association, provided we did not feel that argument was presented which would justify any supporting action of the council. The delegation met this afternoon and have been influenced by what they have seen and heard at the meeting here, and did feel—at least the majority of them did—that the dues should be increased, for one reason, that the dollar is not worth as much as it was ten years ago, and the fact that while we were not entirely satisfied with the—in fact, not at all satisfied with the way money was being expended, yet we didn't feel we ought to cripple our organization because we didn't approve of everything it did by breaking its leg. So the delegates decided not to oppose this action. I think it would have been an idle opposition. Certainly the House is overwhelmingly in favor of the increasing of dues, but in justice to ourselves, and in view of the action of our county society and their attitude toward it, we felt that the statement ought to be made to you about our feelings in the matter.

We know so little about what goes on, that I think the action of all of us, or the opinion of all of us must be largely a matter of impression, and perhaps of prejudice for or against. We don't really know what goes on in headquarters. When we read the account of finances of the Association, we see that salaries are \$2500 to officials that we know are getting compensation closer to ten thousand. Of course, that's not our business. If the Association is paying only twenty-five hundred, why should we worry what they are getting from other sources? But we think the House of Delegates ought to know what is going on in these things.

There are things that make us distrustful.

We in our society at least feel there is a tremendous amount of waste paper and postage, that there is too much coming out of the Secretary's office. Now, as I say, we don't know. We may be entirely wrong. It may be that that is very useful to other people, but it isn't useful to us. In fact, some of our members say it is a matter of the State Board of Health. Mail is sent with three-cent stamps, and it isn't opened. Which may be wrong, but which shows the tempo of a considerable body of our membership.

But we have been moved by the account of it—or I myself—by talking to various councilors, including our own, and we feel that we do not wish to oppose that, but we do wish to make known our feeling of some restlessness as to just how the money is being spent.

For one thing, it has been pointed out to us that we ought to increase the dues because for instance, the chiropractors pay \$400 apiece, and obtain a whole floor of the Capitol Hotel. To me that is no argument at all. We can't compete with that. I don't think an argument of that sort is a very valuable argument.

The action of the House has been taken. We did not oppose it. If we had, I don't think it would have affected the result, because I think the House is overwhelmingly in favor of the increase, but I have taken the liberty of taking your time for this statement because of the attitude of our society and the instructions that we had.

**SPEAKER HOUSTON:** Thank you, Dr. Scott. I think the people who are in the proper positions in the society will take your words to heart.

Do I have a motion to adjourn?

(Upon motion duly made and regularly seconded, the meeting was adjourned at 8:10 p.m.)

# *The* JOURNAL *of the* Kentucky State Medical Association

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## Help Wanted: 1900 Associate Editors

Publication of a State Medical Journal is a sizeable operation. It is also expensive. Printing, paper and postage costs of our *Journal* amounted to more than \$14,000 last year. In addition, it is estimated that the cost of salaries of the various workers of the headquarters staff who write, edit, manage, make up pages, prepare advertising dummies, proof read and perform a multiplicity of other duties in connection with the *Journal* amounts to almost \$5500 annually. Income from advertising is sufficient to take care of printing costs. The remainder is paid from members' dues.

The twelve issues of the *Journal* received annually by each member cost about ten dollars, or 83c per member per month. Approximately 63c is paid from advertising income and 20c from the member's dues.

Publication of the *Journal* is one of the major undertakings of the Association, and like all other associational activities it should be conducted in accordance with the composite wishes of the membership.

Its content should be of sufficient interest that each issue would be pleasurable anticipated and thoroughly read. Scientific articles should be of practical informative value; editorials should convey to the membership the policies adopted by the Association and the Association's attitude toward the subjects with which they deal; the organization section should be a sort of associational newspaper that reflects the activities of the state association and of the county societies.

Good organization requires good communication. Lines of communication function properly only when they operate in two directions. When you receive your *Journal* you see in concrete form our idea of what the *Journal* should be for that month. Unfortunately there is no return communication to inform us of your reaction. In order to publish a *Journal* that is worthy of the Association and worth its cost it would be helpful for us to know a number of things.

We need to know how thoroughly the



*Journal* is read. Do you read it? All of it? Part of it? Which part? Do you read scientific articles only? Organization section only? Do you read the editorials? How does the *Journal* as a whole compare with your ideas of what it ought to be? Which sections are handled satisfactorily? Which ones are not?

In an editorial last month we said that a legislator cannot truly represent a silent constituency. Neither can we give you the *Journal* you want if you fail to tell us what you want. It is your opinions concerning the *Journal* that matter rather than ours. Nevertheless, it is obvious

that if your opinions are to get results they must be conveyed to us to permit their translation into action.

There is no "iron curtain" between the membership and the *Journal* that cannot be penetrated by a three cent stamp. We covet your comment whether it be criticism, suggestion, approval or disapproval. To sum it all up, we are inviting each of the 1900 members of the Association to become a sort of "Associate Editor Without Portfolio." With the interested advice and cooperation of this task force we can have a better *Journal*.

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### Annual County Medical Society Officers' Conference is an Important Associational Function

The second annual conference of county medical society officers will be held on February 7, 1952, 10 A. M., at the Brown Hotel in Louisville, Kentucky. All officers of the Kentucky State Medical Association, all members of the council, the chairmen of all state committees, as well as the president, secretary, chairman of the legislative committee and the public relations committee of each county medical society, are not only cordially invited, but are urged to be present for this very important meeting. In case any of these key people cannot attend, an alternate should by all means represent them.

A program which has been arranged by your officers and the headquarters staff will be even better than that of last year. Speakers of national reputation will be on the program to bring you the latest in public relations, legislative matters, and medical economics in general. A time has also been allotted during the course of the day's meeting for each councillor to meet with the officers from his councillor district in order to go over with them any problems which have arisen in the councillor district as well as to better explain the application of the program within their own county society. In addition a forum has been arranged as a part of the program during which questions may be asked from the floor and answered by a panel consisting of the speakers of the day.

The general purpose of such a meeting is to serve first as a refresher course for

key personnel of all county medical societies. Second, it is to coordinate the work within the several counties, and third, it is an opportunity for the state medical association, which serves chiefly as a policy-maker, in getting over to the county medical societies the program of work for the coming year. Very few of the important points in the Twelve Point program of the Kentucky State Medical Association can be accomplished on a state level. There is only one place that adequate and satisfactory action can be taken and that is on a county level. The county medical society is the basic unit of medical organization within our state just as it is in other states, and it is all important that each county medical society know the policies of the state medical association and know how to accomplish their part of the assigned mission. The doctors of Kentucky still have serious problems in the field of medical service, distribution of physicians, rural health programs, as well as legislative and public relations problems. It is thought that this program should be considered a "must" for the key officers of each county medical society. Those who attended the first annual conference of last year can well remember how profitable as well as how pleasant and instructive this conference was. Please mark the dates on your calendar and be sure that your key officers attend this second annual conference.

R. HAYNES BARR, M. D.

# ORGANIZATION SECTION

## County Officers To Hear National Medical Leaders, Feb. 7



Louis H. Bauer, M. D.

The program for the Second Annual County Medical Society Officers' Conference, a day-long session to be held in Louisville, Thursday, February 7, at the Brown Hotel, has been approved by the Executive Committee.

"We have been very fortunate in securing the calibre of talent that we shall have for this very profitable meeting," Clark Bailey, M. D., Harlan, President of the Association, said.

"We will have at least four men with us, specialists in their own particular field of organizational work, who are recognized nationally for their ability," he continued.

One of the features of the program, the president pointed out, was the luncheon address to be given by Louis H. Bauer, M. D., Hempstead, New York, President-Elect of the A.M.A. Dr. Bauer is a gifted speaker and one of our most astute contemporary medical statesmen, Dr. Bailey said.

An explanation of some of the Association's latest programs will be given at this organizational meeting. This will include the plan of postgraduate instruction by telephone. County society officers will have an opportunity to discuss their local problems with their district councilor, as the councilor district conferences are being held at the same time as the county meetings.

All county society officers, county legislative and public relations chairmen, and chairmen of all state committees will be invited to attend.

## P. G. Instructional Broadcasts To Start Tues., Feb. 26

Arrangements have been completed by the Association in cooperation with the University of Louisville School of Medicine through the Southern Bell Telephone Company for a series of postgraduate courses of instruction, to be made available to county societies starting Tuesday, February 26.

A detailed explanation, covering the operation of the plan, has been sent each county society secretary, Robert Lich, M. D., Louisville, chairman of the Committee on Medical Education, has announced.

The Committee urges each county medical society to carefully consider the advantages of this excellent and inexpensive opportunity and to participate in the programs. If there are any questions, the county officers are asked to contact the Headquarters Office at once.

"The knotty problems of loss of time, transportation and expenses faced by both the instructor and busy practitioner in getting together are obviated in the Association's new plan for postgraduate instruction by telephone," Dr. Lich said.

This recent, but adequately tested method, allows the local physicians to sit in their regular county society meeting places and hear the very latest medical developments discussed in a practical, non-didactic manner by recognized leaders, coming to them in fresh, live broadcasts from General Hospital in Louisville, Dr. Lich stated.

The University of Louisville is providing the programs under the direction of Herbert L. Clay, M. D., the University's director of postgraduate instruction. In addition, the University will send each member of participating county societies a full outline more than 10 days before each program. This outline will contain a liberal number of charts, diagrams and illustrations, which may be followed to the advantage of the physician as the program progresses.

The cost of these hour long broadcasts to county societies will be 50 cents per active member with a minimum of \$10.00 per county.



In addition, the county society will pay for the especially balanced lead-in wire from the local telephone office to the society meeting place, plus the cost of connecting the wire to a loud speaker.

County societies with very small memberships are asked to agree on a common meeting place and to make necessary arrangements for the course. The Headquarters Office will be glad to assist them. An alternate plan is for the small society to arrange to hear the broadcasts at an adjacent county which is subscribing.

Members of the Kentucky Chapter of the Academy of General Practice who participate in the courses will get credit on their 1952 requirements, Dr. Clay said.

### **President Urges Early Election Of County Officers**

County medical societies are urged to elect their 1952 officers and appoint their legislative and public relations committee chairmen at their earliest convenience, according to a statement by President Clark Bailey, M. D., Harlan.

"It is most important that each county medical society in our Association name its 1952 officers and committee chairmen as soon as possible and report them to the Headquarters Office immediately after their choices are made," Dr. Bailey said.

The county societies are asked to do this, he pointed out, in order that the new officers may plan to attend the Second Annual Medical Society Officers' Conference on Thursday, February 7, in Louisville. In addition, the Headquarters Office should have these names so that it may keep the new officers and councilors informed as to the conference.

### **Student AMA Journal to Appear In January**

The first issue of the Journal of the Student American Medical Association will be out in January, George F. Lull, M. D., Secretary and General Manager of the A.M.A., discloses.

The magazine, which will be published monthly except July, August and September when the schools are closed, will have a circulation of more than 33,000. It will be sent to 26,191 medical students and to approximately 7,000 interns.

Russell F. Staudacher, executive editor, said the publication will make it possible for the S.A.M.A. to "provide the young doctor with a

broader realization of the socioeconomic aspects of medicine." It will demonstrate their duties and responsibilities not only as physicians but as citizens, he said.

### **Ky. Doctors Appear On Program of Southern Association**

Kentucky physicians were well represented on the program of the 45th Annual Meeting of the Southern Medical Association, which was held in Dallas, Texas, November 5-8, 1951.

Elmer L. Henderson, M. D., Louisville, Past President of S.M.A. and Immediate Past President of A.M.A. and W.M.A., gave the response to the Address of Welcome at the opening assembly, November 5.

Edwin P. Solomon, M. D., Associate in Obstetrics and Gynecology, and Silas H. Starr, M. D., Clinical Professor of Obstetrics and Gynecology, University of Louisville, were scheduled to present a paper "Elective Induction of Labor" at the section on obstetrics, November 5.

W. V. Pierce, M. D., and W. R. Miner, M. D., Covington, presented a paper on "Benign Tumors of the Ureter" at the section on urology, November 6. Ryle Radke, Colonel, Medical Corps, U. S. Army, Fort Knox, spoke on "The Diagnosis and Treatment of Chronic Amebiasis" at the section on medicine.

Everett G. Grantham, M. D., Assistant Clinical Professor of Surgery, University of Louisville, opened discussion of a paper presented at the symposium on psychosurgery, and William K. Massie, M. D., Lexington, opened discussion of a paper at the section on orthopedic and traumatic surgery, November 6.

Robert Lich, Jr., M. D., Clinical Professor of Urology, University of Louisville, and Chairman of the section on urology, gave the Chairman's Address, entitled "Renal Hypertension," November 7.

Chairman of the section on radiology, Joseph C. Bell, M. D., Associate Clinical Professor of Roentgenology, University of Louisville, presented the Chairman's Address, November 7, on "Some Difficulties in the Diagnosis of Certain Gastric Lesions."

W. L. Cooper, M. D., Lexington, talked on "The Logical Employment of Sigmoidoscopy and Roentgenologic Examinations in Studies of the Colon" at the section on proctology, November 8.

At the section on dermatology and syphilology, November 8, discussion of a paper was opened by Adolph B. Loveman, M. D., Assistant Professor of Dermatology and Syphilology, University of Louisville.

John S. Harter, M. D., Louisville, Chairman of the surgical section, presided at the afternoon scientific session of the American College of Chest Physicians, Southern Chap., November 4. Dr. Harter, Assistant Clinical Professor of Surgery, and W. Burford Davis, M. D., Clinical Instructor in Thoracic Surgery, discussed "Esophageal Achlasia and Hiatus Hernia."

Dr. Henderson is a member of the Board of Trustees of the S.M.A., and Clifford N. Heisel, M. D., Covington, is on the Council.

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## Statewide Diabetes Detection Drive Supported by 66 Counties

Sixty-six Kentucky counties participated in the State's First Annual Diabetes Drive, November 11-17, Carlisle Morse, M. D., Louisville, Chairman of the K.S.M.A. Diabetes Committee, which sponsored the drive, has announced. The Association had the endorsement of and cooperation of the following organizations, a fact which contributed greatly to the success of the drive:

Kentucky State Dental Association  
Kentucky State Hospital Association  
Kentucky Pharmaceutical Association  
Kentucky State Society of Medical Technologists

Kentucky Farm Bureau  
Kentucky Congress of Parents and Teachers  
Kentucky Chamber of Commerce

Following a compilation of the results of the drive, a summarization of it will be published in this Journal.

Kentucky became the 36th state to join with more than 600 state and county medical societies in an effort to detect diabetes, a disease which now ranks in eighth place among the most dangerous diseases in the nation.

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## Southern Medical Attended By 45 Kentucky Physicians

Approximately 45 Kentucky doctors attended the 1951 meeting of the Southern Medical Association, which was held in Dallas, Texas, November 5-8, with a total attendance, at the last report, of around 3,000 physicians.

According to the daily bulletins, the following doctors from Kentucky were registered:

C. V. Atherton, Louisville; Thomas E. Averitt, Winchester; J. C. Bell, Louisville; Warren William Borsch, Louisville; Roger Breyt-spraak, Paducah; W. C. Buschemeyer, Louisville; Shelby G. Carr, Richmond; Wilford L. Cooper, Lexington; Marcus A. Coyle, Spring-

field; Elmer E. DeVillez, Covington; L. S. Durkin, Fort Campbell;

O. Earl Ferguson, Owensboro; Clifton G. Follis, Glasgow; John D. Gordinier, Louisville; Lyman S. Hall, Campbellsville; Michael M. Hall, Campbellsville; John S. Harter, Louisville; Clifford N. Heisel, Covington; E. L. Henderson, Louisville; R. H. Johnson, Louisville; W. O. Johnson, Louisville; Conrad H. Jones, Murray;

David L. Jones, Fulton; Robert Lich, Jr., Louisville; Clarence H. Likins, Jr., Louisville; J. B. Lukins, Louisville; Arthur C. McCarty, Louisville; Jennings B. Marshall, Louisville; William K. Massie, Lexington; David G. Miller, Jr., Morgantown; John C. Miller, Louisville; William R. Moore, Louisville; Carlisle Morse, Louisville;

W. Vinson Pierce, Covington; F. Glover Plymale, Louisville; F. P. Rawlings, Jr., Trenton; Ben A. Reid, Louisville; Virginia G. Russell, Louisville; J. A. Ryan, Covington; Arthur J. Schwertman, Covington; Claude E. Smith, Covington; Edwin P. Soloman, Louisville; M. Carroll Spradlin, Somerset; Silas H. Starr, Louisville; C. Dwight Townes, Louisville.

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## AMA Members to Benefit From New Dues Processing Method

The Membership and Subscription Department of the A.M.A. is disposing of the outmoded methods under which it has been operating, and has employed the management engineering division of a Chicago firm to work out a modern business procedure for the department, George F. Lull, M. D., Secretary and General Manager, has announced.

Under this new operation, punch card methods will be used to handle speedily and accurately the names and addresses of physicians, and the whole setup will take into consideration the membership work that must be carried out by the state and county societies.

When the work is completed (expected within 12 or 18 months), it will be possible for the state and county societies to set up a simple and inexpensive method which will tie-in with the A.M.A. operation. This will assure a much faster and accurate method for all three organizations. The state and county revision in operation will be offered on a voluntary or elective basis.

One of the firm's men working on the job estimated that under the new setup a doctor should receive his A.M.A. membership card in less than 4 weeks. During that time it will have passed through 3 different reporting groups—the county society, the state society and the A.M.A.



## Blue Shield Has Enrolled 21 Million

Twenty-one million people in the U. S. and Canada have enrolled in Blue Shield Medical Care plans, more than 6 million having been enrolled within the past 12 months, according to an announcement November 14 by the Blue Shield Commission, Chicago, national association of the non-profit Blue Shield plans, sponsored by the medical profession.

Frank E. Smith, director of the Blue Shield Commission, declared, 'This is a remarkable tribute to the medical profession. The 115,000 doctors who sponsor the 77 non-profit Blue Shield Plans have given dramatic proof that the voluntary pre-payment principle can be made to work.'

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## New Members of K.S.M.A.

Following are the unreported names of new members, whom we welcome to our Association:

ALLEN—Owen L. Davis, Scottsville;

BOYD—Paul A. Bryan, Ashland; Philip J. Winn, Ashland;

FAYETTE—W. H. Cuthbert, Lexington; Carl M. Friesen, Lexington; Ullin W. Leavell, Lexington; John W. McGowan, Lexington;

GRAYSON—W. C. Robertson, Leitchfield;

HART—C. L. Border, Horse Cave;

JEFFERSON—Philip D. Briggs, Louisville; Seymour Cohen, Louisville; Verne V. Eskridge, Louisville; James R. Freedman, Louisville; I. Wilson Gittleman, Louisville; Andrew L. Hoekstra, Louisville; Edgar B. Morgan, Louisville; Robert B. Nolan, Louisville; Marvin B. O'Neil, Louisville; Charles E. Reddick, Louisville; Jarrett Ringham, Louisville; A. S. Rosenstein, Louisville; John E. Ryan, Louisville; Robert J. Seebold, Louisville; David Shapiro, Louisville; Leonard Singerman, Louisville; William H. Smith, Louisville; Richard C. Spear, Louisville; Clarence C. Starr, Louisville; Thomas S. Wallace, Louisville; Gerald S. Williams, Louisville; Carroll L. Witten, Louisville;

JOHNSON—Charles L. Preston, Paintsville;

McLEAN—Gerald Edcs, Calhoun;

PENDLETON—Frederic C. Hauck, Falmouth

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## US Hospitals Will Be Accredited By Joint Commission

The establishment of a joint commission representing the American Medical Association, the American Hospital Association, the American College of Surgeons and the American College of Physicians for the accreditation of hospitals in the U. S. and possibly Canada was announced October 19 by the Journal of the A.M.A.

This commission will take over the work which was carried out by the American College of Surgeons for more than 25 years. The creation of the national Joint Commission for the Accreditation of Hospitals has been underway since 1950 when the American College of Surgeons found the program too costly for one organization and invited other organizations to discuss the possibility of carrying on the project jointly.

The joint commission will be composed of 18 members: 6 appointed by the A.M.A., 6 by the American Hospital Association, 3 by the American College of Surgeons and 3 by the American College of Physicians. It will be financed by the constituent organizations on a basis proportionate to their representation on the commission.

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## Staff Members Attend Meeting of State Journal Editors

Two members of the Staff of the Journal of the K.S.M.A. attended a two-day national meeting of State Journal Editors in Chicago, November 12 and 13, held in the Auditoriums of the American Medical Association.

The Associate and Managing editors, who represented this Journal, reported a most practical and profitable meeting. The A.M.A. paid traveling and per diem expenses of all the State editors.

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## News Items

Francis M. Massie, M. D., Lexington, announces his association with John R. Burgess, Jr., M. D., who limits his practice to surgery. Dr. Burgess is a graduate of Duke University School of Medicine, Durham, North Carolina, in 1947. He interned at Duke University Hospital and has just completed a 3 year residency at St. Joseph's Hospital, Lexington.

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Glenn F. Bushart, M. D., and Robert W. Bushart, M. D., have announced their association with R. Ruby Jones, M. D., at the Fulton Hospital and Bushart Clinic. A native of Memphis, Dr. Jones is a graduate of University of Tennessee College of Medicine, and recently completed his internship at Jefferson Davis Hospital, Houston, Texas.

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Arthur J. Muller, M. D., has located in Pineville, where he will specialize in radiology. Dr. Muller is a native of Detroit and a graduate of Wayne University College of Medicine, Detroit, in 1943.





The Little Garden Club, Danville, has done a splendid job for several years on the garden at the McDowell House, shown above. Charles A. Vance, M. D., Lexington, Chairman, Board of Directors of McDowell Memorial Foundation, has reported. A total of \$402.62 on labor, supplies, landscaping, planting and purchase of shrubs was spent by this group from 1948 to 1951.

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**Ernest A. Terry, Jr., M. D.**, of Fairfield, Connecticut, has recently associated himself with the General Electric Corp., Louisville. He is a graduate of Columbia University College of Physicians and Surgeons in 1945.

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**John L. Housley, M. D.**, a native of Ohio, has located with Glen Eden Community Center, Williba, Lee County. He is a graduate of New York Medical College, class of 1931.

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**Allen F. Murphy, M. D.**, Cincinnati, is the new Health Officer for Morgan and Wolfe counties. A graduate of the Eclectic Medical College, Cincinnati, in 1926, Dr. Murphy interned at Deaconess and Bethesda Hospital there. He did postgraduate work in dermatology at New York University Medical College, and was admitting physician at Bellevue Hospital for several years.

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**John S. Sprague, M. D.**, Lexington, represented the K.S.M.A. at the national medical civil defense conference, the first of its kind, held in the Palmer House, Chicago, November 9 and 10. The meeting was under the joint sponsorship of the A.M.A., the American Hospital Association and the Association of State and Territorial Health Officers.

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**Cecil Holcomb**, of McKee, has been named president of the Pre-Medical Society at the University of Kentucky. He is a junior in the college of Arts and Sciences.

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**T. M. Turner, M. D.** has begun practice in Morgantown. A 1924 graduate of the University of Louisville Medical Department, Dr. Turner formerly practiced in Centralia, Missouri.



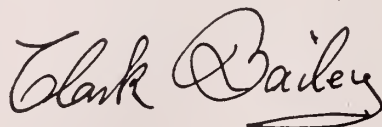
## President's Page

Soon after the explosion of the atom bomb in Japan a group of men were discussing the incident. A professor of biology, who taught me in college, was in the group and stated that the future of the world would be determined by what scientists dreamed about. He further said that nothing great had been accomplished in the world unless it was first dreamed about and he gave several illustrations of emphasis such as the airplane, the steamboat, and the radio. He predicted a period of indecision and then a very definite pattern as to the emphasis of scientific development and its influence on our future world.

It is apparent that the greatest direction of effort in science at this time is in the field of physics. The governments of the world are spending billions of dollars in the study of nuclear fission and the effects of radiation of the atom. The development of electricity, radio, television, radar, X-rays, sound waves, jet propulsion, the rocket experiments make us conscious of the physical complexion of our future world.

We are living in times of accelerated change when the word stasis sounds obsolete. Our field of medicine is in a period of change. Both the extrinsic and intrinsic influences on medicine are great.

Let us, in this period of transition and change, rededicate our efforts at this Yuletide Season that the stature of our profession may be increased and that the spirit of Truth may prevail. Let us work together in unity to this end.



PRESIDENT

# County Society Reports

## BELL

WHEREAS, the Lord, in His infinite wisdom, has taken from our presence our beloved fellow member, Dr. Clyde Russell; and

WHEREAS, Dr. Russell was for a long time a highly respected and influential member of this society and served it in various official capacities; and

WHEREAS, he was not only a faithful and loyal friend, but possessed qualities of mind and soul that commanded the respect and admiration of all associated with him, portraying the highest ideals of the profession, steadily performing the duties of a citizen and friend in peace and war;

THEREFORE, BE IT RESOLVED, that the Bell County Medical Society hereby tenders its profound sympathy to his family and associates and that we incorporate these resolutions in the minutes of this meeting. His loss is indeed a loss to our profession.

BE IT RESOLVED, further, that a copy of these resolutions be sent to the family, to the Kentucky State Medical Journal, The Middlesboro Daily News, The Pineville Sun, The Claiborne Progress and a copy be entered on our minute book.

### BELL COUNTY MEDICAL SOCIETY Committee:

James S. Golden, Jr., M. D. (President)

Charles S. Scott, M. D. (Committee)

Everette G. Lynch, M. D. (Committee)

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## FAYETTE

The regular meeting of the Fayette County Medical Society was held in the Good Samaritan Hospital Auditorium on October 9, 1951, at 7:30 P. M.

The meeting was called to order at 7:30 P. M. by the President, W. H. Pennington, M. D.

The minutes of the previous meeting were read and approved as read.

There were no case reports.

The paper of the evening, the subject of which was "The Importance of and Clinical Management of Surgical Pain," was given by Rufus C. Alley, M. D. The paper was discussed by Drs. Wilford L. Cooper, N. L. Bosworth, John W. McGowan, Orville T. Evans, John Scott, William N. Lipscomb and Dr. Alley in closing.

The application for membership of C. I. Schwartz, M. D., having been approved by the

Board of Censors, was voted upon and he was elected to membership.

Walter Boswell, M. D., for the Committee on Blue Cross Insurance, made a report of no report. The subject was discussed by Drs. Pennington, John S. Sprague and John Scott, and Dr. Boswell was requested to get his Committee to function in the matter and to report to the Society at its next meeting.

The President read a letter which had been addressed to him by the Executive Secretary of the Lexington-Fayette County Tuberculosis Association and also representing the views of the Lexington-Fayette County Board of Health, requesting approval of the Society for a program of patch testing of all school children between the ages of 9-14 inclusive. It was moved by E. J. Murray, M. D., that this action be approved by the Society and there was a second to this motion. However, after discussion by Drs. Carl L. Wheeler, Jr., Elliott, Murray and John Scott, Theodore Adams, M. D., made a substitute motion that the Chair appoint a Committee with power to act to investigate further the advantages and disadvantages which would accrue from the course of action outlined in the letter. The substitute motion was accepted, seconded and passed without dissent. The President appointed Drs. Elliott, John Scott and Adam Miller to this Committee, the last to act as chairman.

In the same connection as the above paragraph, Dr. Murray addressed the Society to the effect that he believes the present situation in Lexington and Fayette County in regard to Tuberculosis constitutes a medical crisis. He pointed out the excessively and uniquely high death rate from Tuberculosis in Fayette County and said that he felt that there were many physicians in Fayette County who do not pursue the isolation and treatment of known cases of Tuberculosis with the aggression that must be applied in these instances if our statistics are to be improved. Dr. Murray especially deplored the fact that we find many cases of Tuberculosis of which we have no way to take care, many times because these cases refuse to come to the hospital. He also deplored the fact that most of the cases now at Julius Marks Sanatorium are far advanced and offer comparatively little in the way of results of the treatment. He remarked that some legal means of enforcing compulsory isolation is what is needed. Such patients who have been found and informed of their disease should then be compelled either to stay at home, go to the hospital or be put in jail. Dr. Murray asked that the same Committee appointed by



the President in the above paragraph be instructed to meet with Mr. McLendon, Sam Marks, M. D., and Miss Virginia Martin with a view to discussing and studying the above outlined situation and presenting recommendations for its amelioration. There being no objection, the President instructed the Committee appointed in the above paragraph so to act.

The two Nominating Committees, as required by the Constitution and By-Laws, were designated by nominations from the floor. The first Committee consists of Drs. E. S. Maxwell, William D. Reddish and M. L. Dean, with the last as Chairman. The second Committee consists of Drs. John Harvey, Jr., Coleman Johnston and Douglas Scott, the last acting as Chairman.

The Delegates of the Fayette County Medical Society to the recent meeting of the Kentucky State Medical Association at Louisville reported their impressions and suggestions concerning the meeting. Dr. John Scott reported how impressed he had been by the speed and the slickness of handling of business by the House of Delegates, and about how little actual information was made available on the floor to the members in attendance at that time. It was apparently assumed, he said, that if anyone there in attendance wanted to know what was going on, he must have known ahead of time that it would be going on and must have found out the proper place to be in attendance at the proper committee meeting in order to acquire such information. Dr. Scott reported that each Delegate was provided with approximately a pound and a half of mimeograph sheets of information about this or that article of business planned for the agenda. Dr. Bosworth discussed the means of transacting business on the floor of the House of Delegates. He moved that there be presented to the Council a Resolution that this mimeograph information be put in the hands of the Delegates six weeks before the meeting of the House of Delegates so as to make it possible for the Delegates to afford the items of their concern the necessary study for intelligent action. Also as a part of his motion, Dr. Bosworth moved that if the Council takes no favorable action on this Resolution, it be presented to the House of Delegates for consideration next year at the Annual Meeting. This motion was discussed by Drs. Douglas Scott, Farra Van Meter, Walter S. Wyatt, and E. L. Moore. It was passed by voice vote without dissent.

Allen L. Cornish, M. D., discussed the difficulty for a new delegate to the Annual Convention to know what was going on, where and how he should make the best use of his time in order to be effective in carrying out the wishes

and seeing to the interests of his constituents. He discussed his belief that as nearly as possible it would be to the advantage of the Society to send the same Delegates year after year to the Convention in order that they may make use of their previously acquired experience to be more valuable to the Society. This same point was further discussed by Drs. Carl H. Fortune and Van Meter, both of whom concurred with Dr. Cornish's views.

Dr. Elliott moved that the Fayette County Medical Society bring before the Council or, if the Council does not take favorable action, before the House of Delegates at the next Annual Meeting, the Resolution that changes in Committee Reports be put in writing and made available to the Delegates to the Annual Convention by noon of the second day of the meeting of the House of Delegates. He also moved that the Fayette County Medical Society similarly bring a Resolution before the Council or the House of Delegates if the Council takes no favorable action that the Slate of the Nominating Committee at the Annual Meeting be given to the House of Delegates at their first meeting. Both of these motions having been seconded, they were passed by voice vote without dissent.

Dr. Theodore Adams moved that the Fayette County Medical Society send to the Council, or, if the Council does not take favorable action, to the House of Delegates at the next Annual Meeting the Resolution of the Society that yearly medals be recognized by the Kentucky State Medical Association only as Memorials to those dead. This motion was seconded and passed by voice vote.

Dr. Pennington reported for the Procurement Committee of the Fayette County Medical Society that he had been told at the Annual Meeting that there appeared to be no need for conscription of medical personnel until late 1952 unless there should meanwhile be a change in the political or military situation. The function of the local Procurement Committee is, he reported, to advise with the State Procurement Committee.

Dr. Pennington announced that the speaker at the November meeting would be Dr. Champ.

There being no further business, the meeting adjourned at 9:25.

John S. Sprague, M. D., Secretary

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#### McCRACKEN

The October meeting of the McCracken County Medical Society was held at the Ritz Hotel with W. P. Hall, M. D., presiding. There were 19 members and guests present.

The scientific session consisted of a paper on

"Cancer of the Colon," presented by W. H. Robertson, M. D.

The application of O. D. Maxey, M. D., was approved by the board of censors. Motion was made and seconded that Dr. Maxey be elected to membership. The motion was passed unanimously.

A motion was made by J. E. Dunn, M. D., seconded by E. L. Blake, M. D., and passed unanimously that G. H. Widener, M. D., be reimbursed for 900 announcement cards. They were \$18.00.

A motion was made by C. B. Billington, M. D., seconded by G. C. Cunningham, M. D., and passed unanimously that the society go on record as approving that physicians with proper facilities do free urinary sugars for any patient requesting such.

A motion was made by Dr. Dunn, seconded by J. A. Ward, M. D., and passed unanimously that the society purchase an amplifying system, the speakers of which are to be installed in a most practical way, and which is to be in the custody of the secretary or some other custodian.

A motion was made by Dr. Billington, seconded and passed that a committee consisting of Drs. Dunn, Ward, and Blake be appointed to purchase and supervise the installation of the amplifier system.

Meeting was adjourned at 9:25 P. M.

G. H. Widener, Jr., M. D., Secretary

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### SHELBY-OLDHAM

The first fall meeting of the Shelby-Oldham Medical Society was held at the Stone Inn on September 27th with C. C. Risk, M. D., as host.

The following members and guests were present: H. B. Mack, M. D., M. D. Klein, M. D., H. T. Alexander, M. D., L. B. Sternberg, M. D., George Perrine, M. D., J. T. Walsh, M. D., S. B. May, M. D., L. A. Wahle, M. D., A. C. Weakley, M. D., H. H. Richeson, M. D., B. E. Sleadd, M. D., A. D. Doak, M. D., B. F. Shields, M. D., E. G. Houchin, M. D., W. H. Nash, M. D., C. C. Risk, M. D., and E. M. Ewing, M. D.

After the dinner the meeting was called to order by the president, Dr. W. H. Nash.

The minutes of the May meeting were read and approved.

Dr. H. B. Mack read a brochure that was distributed to the physicians of the State entitled, "Can I grow up strong and healthy in Kentucky?" He made a protest to the wording of the brochure in regard to the general practitioner's ability in caring for the children of the State. After much discussion Dr. L. A. Wahle made a motion, seconded by Dr. J. T.

Walsh that the Secretary be instructed to write Sam Overstreet, M. D., President of the Kentucky State Medical Association and Bruce Underwood, M. D., Secretary, a letter of protest. Motion carried.

A letter was read from Dr. Overstreet in regard to the appointment of a Committee to be known as a "Diabetic Committee." The President appointed Drs. Wahle, Doak and Sternberg.

Dr. Wahle called to the attention of the Society the lack of interest in the blood bank at the local hospital and asked the members to seek more donors.

At this time Dr. C. C. Risk introduced McDaniel Ewing, M. D., of Louisville who spoke on "Recent Advances in Orthopaedic Surgery." His talk was very interesting and was well discussed.

Meeting adjourned at 9:30 P. M.

C. C. Risk, Secretary

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### SHELBY-OLDHAM

The Shelby-Oldham Medical Society met at the Stone Inn on Thursday, October 25th. B. F. Shields, M. D., entertained.

The following members and guests were present:

Drs. B. F. Shields, H. H. Richeson, A. C. Weakley, B. E. Sleadd, George Perrine, S. B. May, L. A. Wahle, E. G. Houchin, A. D. Doak, L. B. Sternberg, M. D. Klein, H. T. Alexander, M. H. Skaggs, W. H. Nash, C. C. Risk and Drs. George Ray and Sam Overstreet of Louisville.

Following the dinner the meeting was called to order by the President, W. H. Nash, M. D.

Due to the lateness of the hour the minutes of last meeting were not read.

George Ray, M. D., of Louisville was proposed for associate membership by H. T. Alexander, M. D. Referred to Census Committee.

At this time the meeting was turned over to Dr. Shields, the host, and he introduced Sam Overstreet, M. D., President of the Kentucky State Medical Association. Dr. Overstreet spoke on "Terminal Ileitis."

The meeting adjourned at 9:45 P. M.

The next meeting will be on November 29th when M. H. Skaggs, M. D., will entertain.

C. C. Risk, Secretary

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### SCOTT

The Scott County Medical Society met for their regular monthly meeting on Thursday, November 1, at the John Graves Ford Memorial Hospital with the following members in attendance:



Drs. W. S. Allphin, L. F. Heath, H. G. Wells, F. W. Wilt, E. C. Barlow, A. F. Smith, D. E. Clark, Jr., P. H. Crutchfield and H. V. Johnson.

O. B. Murphy, Jr., M. D., and U. W. Leavill, M. D., of Lexington, Kentucky, were guests of the Society.

Dr. Allphin introduced Dr. Murphy who read a most interesting paper on the treatment of fractures with especial reference to the use of the medullary pin in the long bones and early ambulatory treatment to approximate the ends of the fracture.

There being no business to come before the Society the meeting adjourned.

H. V. Johnson, M. D., Secretary.

## *In Memoriam*

**ROBERT WESLEY CONNOR, M. D.**

Owensboro

1887 - 1951

Dr. Robert W. Connor, well known physician and surgeon of Owensboro, died Monday, October 1, 1951.

He was born near Derby, Perry County, Indiana, on September 17, 1887 and attended Marion Normal College, Indiana. He was graduated from the University of Louisville School of Medicine in 1915.

Dr. Connor was a member of the American Medical Association and was Past President of the Daviess County Medical Society.

**EARL CARROLL YATES, M. D.**

Lexington

1898 - 1951

Dr. E. C. Yates died September 2, 1951. He was born in Wheeling, West Virginia, in 1898 and received his early education in the public schools of Pittsburgh. He was graduated from the University of Michigan in 1920, receiving his B. S. degree and his degree in medicine in 1922. He interned at St. Francis Hospital, Pittsburgh. He returned to the University of Michigan for a period of four years post graduate training in Otolaryngology under Dr. Bishop Canfield and Dr. A. C. Furstenberg and in 1927 he located in Lexington as the head of the Ear, Nose and Throat Section of the Lex-

ington Clinic, a position which he held until his death.

Dr. Yates was a diplomate of the American Board of Otolaryngology, a Past President of the Kentucky State Eye, Ear, Nose and Throat Society, Past President of the Fayette County Medical Society and of the Medical Staff of Good Samaritan Hospital. He was a member of the House of Delegates of the Kentucky State Medical Association. He was also a member of the Kentucky State Educational Committee and a director of the Kentucky Physicians Mutual Insurance Company.

His untiring efforts in the State Medical Association were recognized by the awarding of the certificate of merit in 1950.

**WALTER E. WRIGHT, M. D.**

Bardstown

1889 - 1951

Dr. Walter E. Wright, Bardstown, died October 23 after suffering a heart attack. He was a native of Missouri, and was graduated from the University of Louisville Medical Department in 1906.

In 1942, after Dr. Wright had retired from his practice of medicine in Tulsa, Oklahoma, he purchased the famous historical residence known as Wickliffe, which was built by Charles Wickliffe, the first of three Kentucky governors to live there.

**ROBERT GRADY ASHLEY, M. D.**

Mayfield

1897 - 1951

Dr. R. G. Ashley, Mayfield, died August 5, 1951. He was born in Beech Grove, Tennessee, in 1897 and attended the local schools and was graduated from the Vanderbilt University School of Medicine in 1921. He served his internship at Bellevue Hospital in New York City and did postgraduate work at Northwestern University, Evanston, Illinois.

He was an eye, ear and nose specialist at Knoxville, Tennessee, before locating at Mayfield in 1935 where he operated his own hospital and clinic. He served with the SIAC in World War I.

Dr. Ashley was a member of his local county, state and national Medical Associations and had practiced in Mayfield for sixteen years.

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BRUCE UNDERWOOD, M. D.

UNDER THE SUPERVISION OF THE COUNCIL

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LOUISVILLE, KENTUCKY  
1951



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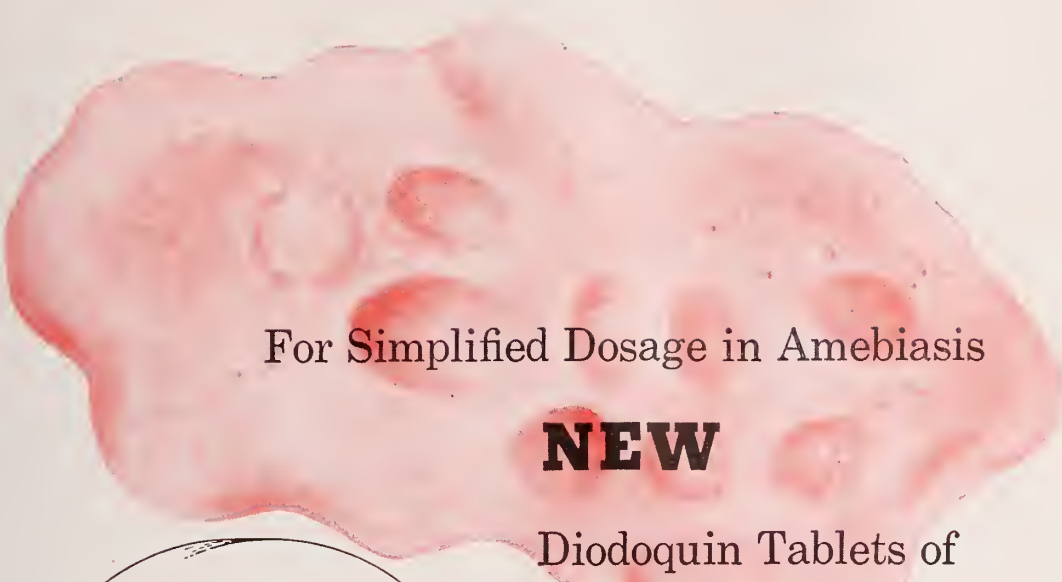
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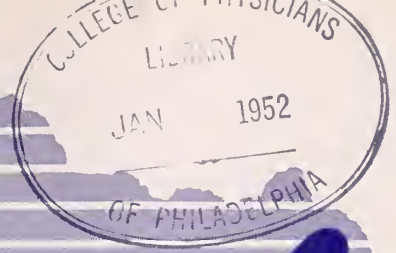
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## OF THE KENTUCKY STATE MEDICAL ASSOCIATION

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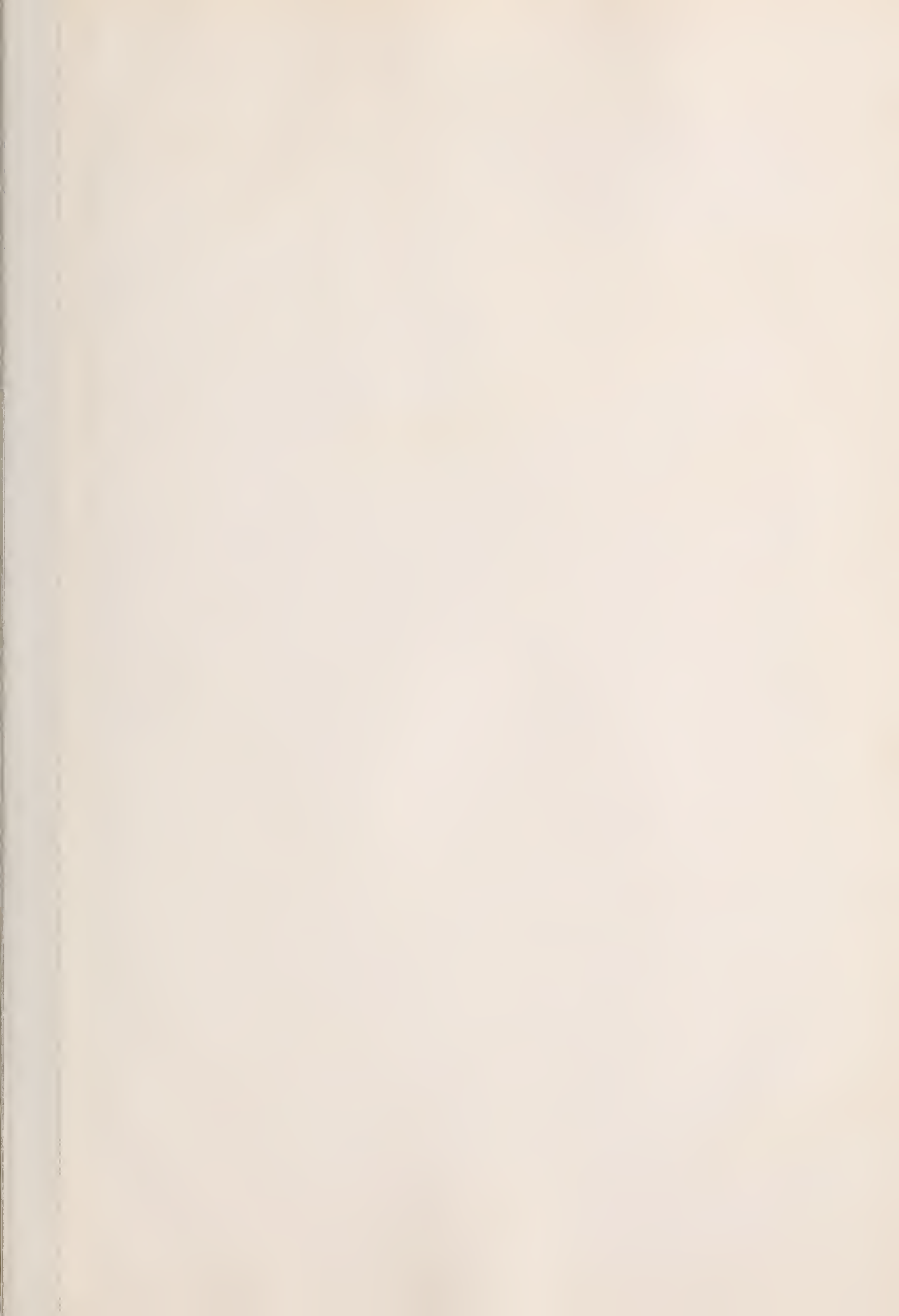
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